International Relief Union

By Col. J. L. BIGGAR, Chief Commissioner, Canadian Red Cross Society

By the creation of the International Relief Union at a conference, held under the auspices of the League of Nations last July, a great forward stride was taken in the organization of the nations of the world for the relief of peoples overwhelmed by calamity. When completely constituted the International Relief Union will substitute for the improvisation of relief in great catastrophes an ordered co-operation of governments and great national and international relief associations. It is to be a permanent association of States for the purpose of organizing and supplying emergency relief to a people overtaken by disaster, other than war, when such disaster is so great as to make the necessary relief a task beyond the capacity of a country in which it occurs.

The father of the International Relief Union is Senator Ciraolo, Honorary President of the Italian Red Cross. He has been deeply concerned in the question for some years and has collected a mass of evidence which proves that for many catastrophes no effective relief is provided; that many times relief material has been delivered to people who were unable to use it because it was unfitted to their needs, their living conditions or their climate; that the offerings made by other governments to a stricken nation savour of charity which makes them a burden to the giver and a mortification to the recipient; that to be really effective improvization in relief work should be replaced by a permanent association of governments and relief societies, of which each nation can enjoy the advantages, not through the charity of others but by means of a reciprocal covenant to which each can look for guidance in preparing its own resources to deal with great disasters, or from which prompt and adequate co-operation could be obtained if the catastrophe be too great for its own resources; and that the permanent preparation of relief measures may be greatly facilitated by the historical and geographical study of calamities in every region of the world, since it is possible to foretell, if not the time at which great catastrophes will occur, at least the type of calamity which may afflict each region.

The idealistic making of the scheme dates from 1921. Its legal making dates from 1924, when the League of Nations suggested certain legal conditions. These legal conditions and rules are essential because such a Union cannot have an existence and an international personality except by diplomatic treaty, and such a treaty can only be the work of governments. The fact that the signatories of the agreement, and thus the founders of the Union as an international entity, must be sovereign states, makes it impossible for the Red Cross to found and constitute the Union.

For these reasons the League of Nations has taken the initiative in creating the Union. The active rôle will belong to the states and to the Red Cross. To combine the action of these two elements, each country will be represented in the Union either by its government or by its Red Cross Society acting as the government's agent. Any government wishing to appear alone in the Union will be free to do so. Any Red Cross upon which its government wishes to

confer this task, and which is willing to assume it, will be free to do so. A country wishing to become a member does so by registering, and by making an initial payment either from government funds or from the treasury of the national Red Cross Society. This is a question of arrangement between the state and the Red Cross.

The project supplies the Union with the organs of legislation, execution and administration necessary to every legal entity, it defines the calamities in which the Union is to act, and the relief which it is to distribute; it provides for the utilization of the Red Cross for all the active work, as well as for the cooperation of societies other than the Red Cross; and it lays down special precautions so that the activity of the Union shall never cross either the sovereignty of states or the neutrality which has to be observed between all of them.

The Union will begin to function when twelve states, representing about one-third of the members of the League of Nations, have ratified the convention. Up to the present the following nine countries have signed: Belgium, Bulgaria, Columbia, Cuba, Ecuador, Germany, Italy, Monaco, and Spain.

The importance of the rôle of the Red Cross in international relief work is emphasized in the section of the draft statutes of the International Relief Union. In this we read:

"It is superfluous to justify the rôle assigned to the Red Cross organizations or to demonstrate their commanding qualifications in the field of international relief work. The Red Cross is the result, in particular, of two diplomatic instruments. The Geneva Convention of 1864 recognized the rights of the Red Cross in connection with war relief work. In 1919, the Covenant of the League of Nations (Article 25) recognized them in connection with peace relief work. The I.R.U. is nothing more than a first application of the latter instrument."

It is not therefore by virtue of any arbitrary privilege that the Red Cross has been chosen as the principal agent to carry out the work of the International Relief Union. In view of its past history it was natural that it should be selected for this rôle, and its activities in calamities all over the world have given it experience in relief work and have won the confidence of nations.

Christmas Joys

The olden days, the golden days,
They all come back to me,
As happily the children crowd
Around the Christmas tree.
I see once more the comrades true
March onward by my side,
I hear the echo of their songs
To greet the Christmastide.

In olden days, in golden days,
My thoughts were high and bold,
But oh the glory of this hour
When in my arms I hold
The gifts that love has brought to me,
They fill my heart with pride,
As I join in their happy songs
To greet the Christmastide.

—William Banks.

Editorials

Christmas-tide is here again and messages of greeting and good-cheer are being exchanged by friends throughout the Christian world. Has the season any special message to nurses? Does the calling of the nurse not give to Christmas a double significance—reminding her of fellowship with sister nurses and fellowship with humanity—humanity for whose service she was especially prepared and to whose service she is daily devoting her life. The word "fellowship" signifies unity: common interests and trust. Through our National Nurses' organization we strive to crystallize and direct the common interests of its members. Those members, scattered as they are over our wide Dominion, have honoured certain members by entrusting to them the direction of the affairs of the Association and of certain important studies and plans. The executive officers and the conveners of these National committees have in our name undertaken heavy responsibilities. Is it not only as they faithfully fulfil their trust, and as we equally faithfully give them our support in the work they have undertaken for us that we shall bring about that unified effort for which our Association stands?

The celebration of the birthday of the Saviour typifies the re-birth or rekindling of an ideal—an ideal of love for mankind and of joy in service to mankind. In the hurry of our modern life, with its tendency to stress the materialistic, there appears to be a danger of losing sight of our ideal—of becoming so tied-up with the mechanics of our particular organization or activity that we lose sight of its purpose. As the Christmas season approaches can we do better than to copy the example of the Sisters of Charity of old in the annual renewal of their vows, and can we not make Christmas the occasion for recalling our pattern and ideal—The Christ—and His love and sacrifice, and re-dedicate our lives to our calling and profession: renewing our efforts to unify the endeavours of our widely scattered members, that through such unity we may the more definitely point our actions and attain our goal?

Members of the Canadian Nurses Association will welcome the publication in this number of the first report from the Study Committee on Nursing of the Canadian Medical Association and the Canadian Nurses Association. This report is being published also in the Canadian Medical Association Journal. While the representatives from the Canadian Medical Association on this committee are not well known to all nurses in Canada, we may be assured that the Canadian Medical Association has chosen wisely in this selection. The nurse representatives need no introduction to our nurses: two of them have honoured the Canadian Nurses Association in the past by accepting the office of president, while the third established the department of Public Health Nursing in one of Canada's largest and oldest universities. Each of these nurses now occupies, and has for some years occupied, a position of outstanding prominence and responsibility. Not only are they deeply interested in the education and welfare of the nurse, student and graduate, and in nursing, but each one has always recognized her responsibility to the public in general and the great privilege it is for the individual nurse to be able to contribute to the building up of a progressive, virile people in Canada. We are indeed most fortunate in being represented by these leaders.

The report of the sub-committee, which was composed of our representatives, has become the general basis of the study. A point emphasized by the sub-committee is that the report is not a plan of study, but rather a suggested outline of the scope of the various studies that will be needed before final conclusions can be reached. It is necessary for us to bear in mind that the general activities of the committee will in time spread to all parts of Canada.

The part for each nurse in Canada now is to act on the suggestion made by the committee in its first report on progress: "It is the desire of the committee that the medical and nursing professions should be fully apprized of the progress of this work, and that they endeavour to familiarize themselves with the facts underlying the many questions that are more or less controversial at present."

Organizations of nurses wishing to have their members kept informed of the progress of this committee are advised to remind their members that interim progress reports will be published in The Canadian Nurse. (One more reason why subscribers should renew promptly, old subscribers renew, and "intending-to-subscribe-for-the-first-time" members send in their subscriptions without further delay.)

Twenty Years A Public Health Nurse

The Public Health Nurses Association of the Department of Public Health, Toronto, celebrated a unique event and one of significance in the world of public health nursing at their annual staff party on October 14, 1927.

Miss Janet Neilson was the guest of honour. On that day she completed twenty years service with the Department of Public Health. She began as a public health nurse in the clinic for tuberculosis at the Toronto General Hospital, which Dr. Parsons started.

Special interest was lent by the presence of Miss Mary Agnes Snively, the founder of the training school for nurses of the Toronto General Hospital, who first advised Miss Neilson in the work she had undertaken as a district nurse. Miss Snively described vividly conditions under which they began.

Dr. Parsons spoke in a reminiscent way of conditions under which they worked in the clinic at that time, and one realized something of the trials of pioneers.

Miss Eunice Dyke, the Director of Public Health Nursing in Toronto, who was next associated with Miss Neilson in the department, also spoke, and a glowing tribute was paid Miss Neilson in the form of a letter from Dr. Chas. J. O. Hastings, Medical Officer of Health.

A presentation was made to Miss Neilson by the Public Health Nurses Association and also a small gift book was given her as a souvenir. It contained pictures of many of those who have been associated with her throughout her career as a public health nurse.

A Rotary Institute for Diseases of the Chest

By H. A. RAWLINGS, M.B. (Tor.), Vancouver, B.C.

The Rotary Institute for Diseases of the Chest was established in 1918. It was built out of funds raised through the efforts of the Rotary Club in Vancouver and has since 1920 been operated by means of municipal grants. It is open from 9 a.m. to 5 p.m. every day except Saturday, when the closing hour is 1.00 p.m.

All examinations are entirely free, but the class of patient accepted for examination is a restricted one. Two classes of patients are accepted: first, those absolutely indigent; and, second, those who are under the care of their family physician but have insufficient means to pay for a special examination, including laboratory and x-ray and any other procedure which may be desirable. The first group are admitted without question upon signing a slip which states that they are indigent and can neither afford nor have been attending any physician. The second class are admitted only upon presentation of a request in writing from their physician. The former group upon the completion of the examination are told what their condition is. The latter group, however, are not informed at the clinic of the diagnosis, but a letter is forwarded on the day following examination to their physician.

Examinations include the following procedure: general examination with special attention paid to the chest; ear, nose and throat examination, including transillumination of the sinuses; tuberculin skin test; urinalysis; x-ray. Indigent cases requiring treatment, either medicinal, heliotherapy or pneumothorax, are given such treatment at the clinic on the days appointed. Those patients received from their own physician for examination may receive such treatment also at the request of their physician.

While essentially the clinic is for the purpose of diagnosis of pulmonary tuberculosis, it is obvious that the majority of chest conditions will be non-tuberculous. Between 20 and 25 per cent. of all new cases examined at the clinic are suffering from tuberculosis in some form or other. Non-tuberculous conditions include neoplasms of the chest, pulmonary abscess, asthma, chronic bronchitis and such like. About 25 per cent. of the

total examinations in the course of a year are carried out on children.

In addition to the strictly medical work in the clinic proper, where two nurses and a technician in addition to the medical director are employed, field nursing in the interests of patients who have been diagnosed as tuberculous in the clinic is also carried on through the agency of two district nurses. These district nurses are equipped with small automobiles to expedite their transportation over the very large area in Greater Vancouver over which they have supervision. In addition to caring for the patients directly diagnosed in the clinic any physician in Greater Vancouver has the privilege of requesting the services of these two nurses. The extent of the activities of the district nurses may be appreciated when it is learned that during 1926 these two nurses made 4,816 visits, which included 648 requiring bedside care.

The total number of patients calling for consultation at the Rotary Clinic during 1926 was 6,291, of whom 1,669 were entirely new patients. Of the new patients, 455 had tuberculosis in some form or other—a little more than 25 per cent. During the same year 1,600 x-ray plates were taken and 2,100 fluoroscopic examinations made. The year's work also included 222 pneumothorax treatments and 340 tuberculin tests.

Although not under control of the clinic the Rotary Fresh Air Camp has certain affiliations, in that the camp was founded and is operated entirely by the Rotary Club of Vancouver. At this camp for a period of two weeks at a time some thirty children are constantly maintained during the school holiday period. These children are not actively tuberculous, but come from homes in which there has been tuberculosis and are usually of the mal-nourished type. Special food, fresh air, sea bathing and a healthy out-door existence during their short holiday has proven very beneficial.

The Rotary Fresh Air Camp at Vancouver, B.C.

By HATTIE B. INNIS, Superintendent

In the city of Vancouver a great deal is being done to develop a well-rounded health education for school age and pre-school age children. Nowhere, possibly, is this programme more necessary than in the summer camps for undernourished children.

At the Rotary Fresh Air Camp the aim is to radiate an atmosphere of healthy living for "healthy thoughts, like butterflies, lead us under sunny skies." Boys and girls soon learn to observe the rules of health, just as they learn to obey the rules of any other game earnestly played.

The camp is situated on Marine Drive, overlooking the waters of the gulf; the view is glorious and the sea breezes most refreshing, particularly on hot summer days. The camp is open for two and a half months in the summer and accommodates thirty-six children: eighteen girls and eighteen boys, ranging in age from four to sixteen years. The children are T.B. contacts, T.B. suspects, and underweights, selected by the nurse in charge of the Rotary T. B. work. Each child is given a two weeks' holiday. In special cases the time is lengthened to three or four weeks. Two weeks is a short time for positive health achievement, but by living each day in the open, having regular hours, nutritious food, good rest periods, supervised play and health education, it is hoped that some seeds at least will fall in good soil. Regular habits count for much, as can be noted from the following daily schedule:

7.30 a.m.—Rising hour.
8.00 a.m.—Breakfast.
8.30 a.m. to 9 a.m.—Making beds and tidying dormitories.
9 a.m.—Inspection, followed by play on the grounds.
10 a.m.—Beach: fishing, games on the sand, hiking, etc.
12 noon—Return to camp; preparation and quiet rest before dinner.
12.30 p.m.—Dinner.
1—3 p.m.—Rest period: absolute quiet; reading.
3 p.m.—Beach: swimming.
5 p.m.—Preparation and rest for supper.
5.30 p.m.—Supper.
6 to 7 p.m.—Play on grounds, concerts, sing-songs, indoor games, popcorn roasts, etc.
7.30 p.m.—Bed time stories; "lights out."

"Weights" are a great feature of the camp and some gains are quite remarkable. Worth-while results, however, are not limited to gain in pounds. In some of the children who have gained little or nothing in weight a marked improvement in vitality is found, while in others of nervous, highly-strung temperaments, the art of relaxation is partially learned.

The play spirit of "wanting to do" has plenty of scope at the weekly concerts, where health plays, songs, fairy dances, bands, making moving health pictures, posters, building model healthlands, etc., are carried on by the children.

Since most of the children who come to the camp are deprived of open-air exercise at home a special effort is made to include it in the health programme. Sports of all kinds, team games, cricket, baseball, horseshoe, swimming, tramps, all these make an important contribution to a child's physical life. Through team games, too, the boys and girls learn to subordinate the individual to the group and "to play the game" in spite of difficulties. Every child is a member of the camp library. Regular periods twice a day are arranged for changing books, which are read during the afternoon rest period and before the morning rising bell.

The children are grouped according to ages for bedtime studies: and how they enjoy them! Travel tales arouse in them the desire to know of the world and all the different peoples, and a really funny story helps to make things bright again for those who were seeing the world through blue spectacles. A carefully chosen story will often help to correct an unfortunate habit.

Although thirty-six children every two weeks make a large and ever-changing family for two to manage, the aim is to establish a point of contact with each child, which is an invaluable help in studying their temperaments and individualities.

To work with children is, from many points of view, the most important and interesting of all tasks. Constant companionship with children, studying and endeavouring to understand the child-nature, treating them when ill and teaching them how to keep well, is a rare privilege. None realize this more than the friends who have made this camp possible: the Rotarians themselves, whose motto is "Service above Self."

Every task, however simple, sets the soul that does it free,
Every deed of love and mercy, done to man, is done to Me.

—Van Dyke.

The Study Committee on Nursing of the Canadian Medical Association and the Canadian Nurses Association

The nursing problem was the subject of a conference held in Toronto in June last. Representatives were present from the Canadian Nurses Association, the Canadian Medical Association and the Provincial Hospitals Associations. Resolutions were passed requesting that a Study Committee be formed, consisting of three representatives from the Canadian Nurses Association and the Canadian Medical Association respectively, and one, who must be a layman, from the Provincial Hospital Association of the province in which the committee will most regularly meet; and further, at the request of the nurses, that the expenses of the committee for the present be borne equally by the Canadian Nurses Association and the Canadian Medical Association. These resolutions were forwarded to the bodies interested, with the result that the committee of seven was formed under the chairmanship of G. Stewart Cameron, Peterborough, who, with A. T. Bazin, Montreal, and Prof. Duncan Graham of the University of Toronto, represented the medical profession. Miss Jean Gunn, Toronto General Hospital; Miss K. Russell, Director of the Department of Public Health Nursing, University of Toronto; and Miss Jean Browne of the Canadian Red Cross represented the nurses. The seventh member has not yet been appointed. In explanation it may be said that as the committee has to meet frequently it was thought advisable to choose the personnel as far as possible from one locality. The general activities of the committee will in time spread to all parts of Canada. The Canadian Medical Association authorized the expenditure of not more than $300 for the current year, and the Canadian Nurses Association will, it is believed, authorize the expenditure of a similar amount.

Two meetings have been held so far. After a general survey of the situation at the first meeting it was decided that the nursing members should form a sub-committee to draft a general statement of the points to be considered in the study. This report—published in full below—was submitted to the full committee on October 8th, 1927, and after long and careful consideration it was resolved that the report should form the general basis of the study.

In publishing this note, it is the desire of the committee that the medical and nursing professions should be fully appraised of the progress of this work, and that they endeavour to familiarize themselves with the facts underlying the many questions that are more or less controversial at present.

Report of Sub-Committee

The report of the sub-committee is not a plan of study but rather a suggested outline of the scope of various studies that will be needed before final conclusions can be reached. It is not claimed that this is a complete statement, but it is hoped that it may serve as a basis of discussion for the whole committee.

I. **The Demand.**

Studies to be made in selected communities concerning the kinds of nursing service wanted, the essential content of each kind and the number needed in each of the following classifications:

1. Hospital nurses—graduates.
2. Hospital nurses—undergraduates (students).
3. Private duty nurses.
4. Practical nurses.
5. Public health nurses.
6. Any others.

II. **The Supply.**

The number of each of the following now on active service:

1. Hospital nurses—graduate.

2. Hospital nurses—in training.
3. Private duty nurses.
4. Practical nurses.
5. Public health nurses.
6. Any others.

The geographical distribution of present service in each group by exact figures and maps.

Comparative studies of demand and supply.

III. **Nursing and the Public.**

1. The kind or kinds of nursing service required.
2. To what extent are the present types of nurses meeting the needs of the family.
3. What change in the character of the nursing service, if any, is sought by the family.
4. Study of the economic resources of the average family for nursing service.
5. Study of the community responsibility for the care of the sick.
6. Relationship between this service and other community services for which the cost is shared.

IV. **Hospital Needs re Nursing.**

Study of a selected group of

1. General hospitals: large, medium, small, very small;
2. Special hospitals: large, medium, small, very small,

in regard to:

Number of nurses and other personnel employed,

Number of nurses and other personnel needed,

The present demands on the nurse for service other than bedside nursing in each of the above types of hospitals,

The essential content of the nurse's work in hospital bedside nursing,

Strength of the present service or tendencies,

Weakness of the present service or tendencies,

The hospital private patient and nursing care,

Study of possibilities to relieve the nursing personnel of non-nursing duties,

Study of the relation between the time spent by the pupil nurses in the class room and the lack of nursing care in the wards.

V. **Private Duty Nurses and the Medical Profession.**

Studies made in consultation with the medical profession concerning:

1. Source of supply of nurses, e.g., professional registry, hospital registry, commercial registry, and others.
2. Proportion of nurses satisfying needs of the case from the standpoint of the medical profession.
3. Proportion of nurses not satisfying the needs of the case from the standpoint of the medical profession.
4. Further studies of the causes of dissatisfaction.
5. Study of the demand for practical nurses.

VI. **The Nurse.**

1. The inducements of the profession.
2. The satisfactions of nursing.
3. The economic aspects:

   Average length of service,
   Average income in each branch,
   Average living expenses in each branch,
   Range of income in each branch,
   Length of service in relationship to income,
   Disabilities,
   Financial opportunities, such as insurance, etc.,
   Cost and opportunity of post-graduate training.

4. Hours of duty.
5. Study of:

   Loss of nurses from the profession,
   Turnover within the profession,
   Extent of and reasons for emigration to the U.S.A.

VII. **Nursing Education.**

1. Hospital schools:

   Number of schools in general hospitals with number of pupils,
   Number of schools in special hospitals with number of pupils,
   Cost of the training school to the hospital,
   Evaluation of the work of the student nurse to the hospital,
   Comparative cost of nursing service in hospitals not conducting training schools,
   Length of course,
   Hours on duty.

2. Preliminary education required in various types of schools.
3. Study of the curriculum from the standpoint of both theory and practice.
4. Study of the qualifications of the present teaching personnel.
5. Post-graduate opportunities:
   (a) in hospitals,
   (b) in universities.

VIII. **Study of the Professional Registration Acts in Canada.**

The Future of Nursing Education

EDWARD F. GARESCHE, S.J.

The subject which forms our title is without question the burning topic of the hour in hospital circles. The nursing profession, as we well know, has had a swift and singular development. A few decades ago hospitals were beginning what were then called training schools for nurses, with the idea, of course, of increasing the ranks of graduate nurses, but often with a very strong ulterior motive of securing workers for the hospital who would help without salary while they were student nurses, and would thus lessen the economic burden of the hospital.

Thus the work was begun of creating a new profession, but this profession soon became dissatisfied with the primitive conditions of the schools of nursing which had given it birth. Through the nursing organizations and through the interest of friends of nursing, laws were passed, regulations established, standards raised, until now the school of nursing is one of the most difficult and exacting of all the departments of hospital work. Instructresses in nursing schools are required to have more and more preparation, expensive and well-equipped homes for nurses are being built, sometimes at a cost of a million or more of dollars for a single hospital. The working time of the student nurses is being shortened and their study time increased until nursing education is approaching perilously near the point where the school of nursing will be a financial burden rather than a benefit to the hospital.

Already some hospitals have given up their schools of nursing, declaring that the requirements are so difficult and the burden so great that it is no longer worth while, from the hospital standpoint, to continue the school. This may be a serious mistake from the viewpoint of the higher interests of the hospital, but it is a significant sign of the times. Add to this that the movement for standardization (and we do not here refer to the voluntary committee which is working on this subject, but to the general movement towards standardization of the schools) is raising more and more the requirements for nursing training. This will mean that the small school may find itself unable to keep up with the increasing educational requirements and so nursing education will be concentrated in larger institutions.

This is what has happened in the case of medical schools and to the advantage of the medical profession, but such a development in nursing would, it would seem, tend to change very materially the whole concept of the nursing profession and to make nurses more like doctors. The daily ministrations of the nurse at the bedside of the patient could hardly be profitably performed by such highly educated, specially trained professional folk. They might make visits, as doctors do, to give special treatments or supervise the nursing, but they would be no longer "bedside nurses" as we understand the term today. This condition will inevitably result in the demand for a less-trained, less-specialized bedside attendant, who would be pretty much like the graduate nurse of today, or at least of yesterday.

We must always remember that the work of nursing, like the work of the physician, has gone on for ages. There was a time, not very remote in history, when barbers were surgeons and when the only education for the physician was to go into the office of another physician or his home and learn from him all that could be learned about his art. So, also, in ancient times, one nurse instructed another. The profession of

(In "Hospital Progress," September, 1927.)

medicine developed and became systematized much more rapidly than that of nursing, because the technique of medicine and the science of medicine are of their nature more specialized, complicated, and difficult. In fact, it is the development of medicine and surgery that has assisted the development of nursing as a profession. The nurse of former days, when methods were very simple and knowledge very elementary, when modern treatments and ways of diagnosis were unknown, was also, necessarily, simple in her needs, and did not require a very extensive education. The reason why she needs such an education today and will need it increasingly in the future, is because modern medical and surgical technique requires skilled and trained nursing to make it effective.

Some time ago a nurse of a great deal of experience who had attended a conference on nursing described to us with interest a two hours' discussion by nurses to which she had listened, in which not a single word was said of the patient. The whole attention of the conference was centred on the nurse, not a thought, apparently, of all those who spoke, strayed aside even for a moment to the patient. Yet it is more true of nursing than of medicine that the whole purpose and life of nursing is to work for the patient's welfare. Medicine, as a science, may go apart, to a certain extent, from the interest of the patient, and study merely the marvels of the human body; but nursing is meaningless save in so far as it ministers directly or indirectly to the care of the sick.

These thoughts are timely ones at this critical transition point in the history of the nursing profession. The course of events is to some extent beyond our control, and the profession of nursing will develop whether we like it or not along the lines in which the logic of events compel it to develop. But we can, by taking thought, modify and direct the course of its development. All the counsel of experienced and sensible persons and their combined thought and care are not too great a price to pay for the right guidance of this most rapidly developing of the professions.

Toxin-Antitoxin Mixtures

The late Sir William Osler is credited with having said that the man who gives medicines is putting drugs of which he knows little into bodies of which he knows less. The matter is still further complicated when we use biological preparations, for many of which there exists only biological tests. These facts and the great increase in the use of biologicals have caused our government to throw around their manufacture and sale the greatest possible safeguards. The wisdom of this precaution and its efficacy is attested by the remarkable infrequency of untoward results, notwithstanding the millions of injections which are made and the fact that many physicians using them have had no special training in their use. In New York City alone, more than half a million treatments of toxin-antitoxin have been used without any bad results.

In 1924, near Vienna, Austria, 34 children received prophylactic injections of toxin-antitoxin mixture, 7 of whom died as a result. Persons opposed to prevention at once seized upon the occurrence to frighten parents against further use of the preventive. An official order in Austria prohibited further inoculations, pending inquiry as to the danger or unreliability of the method.

The matter was referred to Professor Grassberger, who, with three

assistants has made an exhaustive study, taking into consideration every possible contingency. Fortunately the stock preparations as well as a number of ampoules filled with them were available for tests. Seventy-six of these were definitely toxic and sixty definitely harmless, corresponding to the contents of the stock bottles. The only conclusion possible is that an error was made in filling one series of ampoules from a stock solution of diphtheria toxin instead of toxin-antitoxin. In other words, the human factor was the one which failed in this case, and there was nothing in the occurrence which can be charged against the prophylactic use of the toxin-antitoxin mixture.

A somewhat similar case will be remembered as having occurred in Massachusetts in 1924. At that time the investigation showed that the mixture had been exposed to extreme cold, and it was believed that the freezing had led to some dissociation of the toxin and antitoxin. Warnings were sent out to physicians against using material which had been subject to freezing in spite of the fact that it was shown that ordinary freezing, and even freezing for 48 hours at a temperature as low as 10°, produced very little physical change in the mixture. Further, it was pointed out by Park that in the mixtures now used in this country the amount of toxin is so small that even the greatest possible dissociation would not be sufficient to produce any serious effect. The investigation of Grassberger showed also that freezing does not make the mixtures dangerous, nor do exposure to sunlight or chemical alterations due to the composition of the glass container produce serious changes.

As long as the human factor enters into such procedures occasional accidents must be expected. When we compare the certain protection against a highly fatal disease with the very small number of accidents due to this human factor, it is plain that there is no reason for alarm about the use of toxin-antitoxin for prevention of diphtheria. It would be just as rational to discontinue the use of railroads, on which frightful accidents still occur in spite of the perfection of apparatus and automatic control which has been attained.

The health officer is peculiarly well placed to carry these facts to his public and to answer the queries which arise in the minds of honest doubters. The facts should be known to all and the absolute truth told concerning such unfortunate occurrences. The cults will unquestionably use them against rational medicine as they always have done. It is our part to answer them with facts.

(Editorial, American Journal of Public Health, November, 1926.)

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
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Psychology

Fear

(**Note**:—Delivered as a model lesson to the students of the Nurse Instructors' Course held in London, Ont., July, 1927, and published by kind permission of Miss Ethel Teasdall. The following shows the development of the subject as a lesson.)

Introduction—which serves as a connecting link to relate the past experience of the student to the new subject—The Nurse's Need of Psychology.

Lesson (proper)—Introduction of specific phase of Psychology, e.g., Fear.
—Place of Fear in racial history.
—Fear as an instinct, and also considered as an emotion.
—Characteristics of Fear.
—Application of the Study of Fear to our professional needs, e.g., Fear of patient and reaction to hospital routine.

Conclusion—Some suggestions to overcome Fear.

Textbook used—The Psychology of Nursing: by Aileen Cleveland Higgins, 1921.

Fear

Perhaps you as nurses wonder why time and space is given to the study of Psychology — that science of mental life—in your training course programme. However, it seems most fundamental since you are going to deal so intimately with people, especially sick people. Often back of physical disturbance is a mental kink. Thus to be able to understand that mental force, its equipment and reactions under various circumstances for the ultimate healing of mind and body, is the reason for its place in the curriculum.

Psychology today is a part of our everyday life. As it has been said, you have only to glance at the attractive sign posters in street cars, shop windows, and alas! often in the countryside, to see how it is used by the salesman and the merchant. Those of the legal profession have asked for means to measure the truth of testimony. The philosopher asks for an explanation regarding human conduct, and the teacher demands facts showing mental growth and uses it for a measuring rod, as it were, to evaluate and ascertain the results of his own teaching methods. The physician and the priest look for psychological methods to cure sick souls and ailing minds.

The phase we are going to consider more particularly for a short time is fear—the first instinct to appear in infancy and the last to disappear in old age or before the ravages of a mental disease.

Angell has said that "Instincts are racial habits transmitted by heredity to the particular individual." You can readily see how fear may be classified as one of these unpremeditated reactions. In babies, fear is in evidence, with its appropriate motor expressions, long before experience has afforded opportunity to observe or copy these in others.

Looking back in the history of the race we find that nothing defeated the great Life principle. Climatic changes demanded heavier coats of fur for the animals and protective colouring and measures for animal life. Polar bears, birds and insects assume the harmonious tints of their surroundings. Clams developed shells, snakes were provided with poisonous fangs, and so on. It seems that all development and growth came from overcoming difficulties, and

fear was the stimulus behind that conquering power.

Fear, then, has an energizing influence. Under this impulse men have been known to achieve extraordinary feats of running and leaping, and have been given tremendous powers of endurance. All have heard many tales of people stimulated by fear doing seemingly impossible things, such as the boy who was pursued by a savage animal leaping over a very high wall. There are numerous instances of things done in the Great War by people who were really and honestly "frightened to death" all the time, and brave enough to admit it.

McDougall "assumes that fear, born of innumerable injuries in the course of evolution, has developed a foreshadowing of possible injury and is therefore capable of arousing in the body all the offensive and defensive activities that favour the survival of the organism."

We see the place of the fear instinct, but fear may be classed as an emotion as well, and it is difficult for us to realize how much the emotion fear enters into and controls our daily life; because as a rule it is subconscious and we do not recognize it without thought and self-examination. Fear plays an important part in guiding our footsteps across each crowded thoroughfare these days.

The next definition is one of James', comparing emotions with instincts: "An emotion is a tendency to feel and an instinct is a tendency to act characteristically when in the presence of a certain object in the environment." We are afraid, and we are conscious of a dread—then the element of knowledge enters and the emotion of fear is experienced. "True emotion distinctly implicates an element of knowledge—we know something which inspires our dread."

Both instinct and emotion are psycho-physical processes. Mind working with body. People in a panic rush aimlessly about or stand stock-still. A person writing and most intent. Suddenly the telephone bell rings. He jumps up. Consciousness and interest are blocked for the time and the mind must make other adjustments quickly. "Emotion" moves us: hence the word itself. When a shock is experienced, we are stunned and a short period of voidness ensues.

What are the characteristics of fear? We have all experienced many of them. Pallor and trembling, spasm of heart action, appearance of goose-flesh, cold sweat, bristling of the hair, dryness of the mouth, a choking sensation, paralysis of the voice, or hoarse screaming, together with a desire to run away, accompanied by a feeling of weakness. Fear sometimes causes people to act stiff and unnatural.

Fear comes in children with strange objects, strange places, by being left alone, by darkness and by noises. All strange situations excite fear, curiosity or anger. A dog sniffles strange objects, then barks, but he is quieted by a friendly, known voice. Thus in familiar things comes adjustment. Most interesting are the accounts of Prof. John B. Watson, Johns Hopkins University, of his tests of the fear instinct in infants. The indication of the presence of fear is made manifest when all means of support is suddenly taken away from the baby, or when the blanket is placed over its head, or loud sounds made.

Knowing that strange situations excite fear, we are better able to appreciate the feelings any patient may entertain entering a hospital. A well person goes about confident that he is able to look after himself; in sickness that confidence is weakened and the instinct of self-preservation comes to the rescue. The hospital stands in the minds of many as a great, unknown Castle of Misery: a place to suffer in: a place in which to die. If the incoming patient finds himself in the presence of a sym-

pathizing friend at the door the first crippling effect of fear is lessened.

Put yourself in the patient's place. Remember how strange the very corridors looked when you first entered. Talk pleasantly and go quietly about making the patient comfortable, until he feels a soothing sense of being cared for and looked after. Show that you are friendly and capable: inspiring confidence, courage and trust; for confidence wards off fear. Patients enter with various feelings, sick in body and facing a great dread. Some with trembling hands, questioning eyes, afraid that "things won't go right." Some are anxious for the people at home: wanting them; or else fearful that they may not be able to carry on the support of the family. We cannot attempt to enumerate these for they are as individualistic as the patients themselves. But, nevertheless, it seems that all are "extra nervous"—some not admitting fear.

The sick are very much like little children and don't want to be left alone, especially at night. The hospital sounds and various noises are strange and fearsome until the nurse cheerfully tells what they are. It has been said that "the night nurse needs particularly to take into consideration the instinct of fear, as manifested in little ways." The fear of taking an anaesthetic, his own helplessness, fills the patient with terror, and the dressing tray with its implements of torture and mysterious small bundles: for even simple instruments look very dreadful if a person has no idea whatever of their use. The knowledge that certain tests have to be made, or a trip to the x-ray room causes alarm which may be entirely eliminated if the nurse explains the procedure to the patient in terms he can understand. But back of all the lesser fears is the great fear of death, unmentioned as a rule. Some patients try to overcome it by religious devotion, others by philosophic reflection, and others by nervous, flippant jests.

Many attempted flights from hospital are the result of fear. We may find an explanation for hospital suicides, especially of foreigners—shut off from understanding of hospital routine by barriers of language—when we realize that the terror of the strangeness of institutional life often changes into utter despair. Sometimes patients thrust away appliances used in treatment; children hide under bed clothes: pushing, kicking and crying.

Then there is the fear of mental disease. "A phobia is an insistent and engrossing fear without adequate cause as judged by ordinary standards." We have the fear of open places (agoraphobia); fear of closed places (clautrophobia)—people who go to church or to the theatre but who must obtain aisle seats, to sit with one foot in the aisle; and the fear of contamination (musophobia). We have fear in delirium and hallucinations.

Patients watch the faces of doctors and nurses. Speech is usually guarded and a professional mask is of one's own making, and the facial mask is of great service. Never allow a patient to know you are afraid by your own expression. "After a critical hemorrhage, a patient once remarked, 'My nurse looked and acted just the same. I didn't know anything dangerous was happening. I should have died of fright if I had guessed the truth.'"

In order to assist the patient to overcome this hospital fear to some extent, the nurse must assure the patient that she is trustworthy and capable; a strong anchor to hold the weary storm-tossed craft in a troublesome sea; sympathetic in his sufferings, interested in his well-being, and mindful of little attentions. Try to lead the sick one to realize that the world is a system of co-operative friendliness: everything working together for the patient's good. Suggestion is a powerful factor to lessen fear. Some children

were playing together during a severe thunderstorm. One child was terrified, because he had known grown-up people at his house to show fear at such a time and had listened while they talked about how they dreaded thunder claps and lightning. The other children in the group were not afraid. The thunder was simply a bigger bang than fireworks; or sometimes they pretended it was a huge giant's chariot racing in the clouds with heavy noisy wheels; and instead of being cold in dread, listening for the next thunder clap, they rather fancied a closer view of the giant himself. Sometimes little rhymes help children to overcome the fear of darkness—such as this one of John Martin's:

The dark is kind and cozy,
The dark is soft and deep,
The dark will pat my pillow
And love me as I sleep.

. . . . .

God made the Dark—so Daytime
Could close its tired eyes
And sleep awhile in comfort
Beneath the starry skies.

Fear must be overcome by the individual himself. We have to substitute faith in place of fear. As it is known the more we conquer, the more easily we conquer: thus forming a habit of conquering. Basil King has said: "After all, the conquest of fear is largely a question of vitality: those who have the most life are the most fearless." So it resolves itself into a problem of vitality: good health, the maintenance of which is in your hands.

Happiness

It's no in titles nor in rank;
It's no in wealth like London bank
To purchase peace and rest;
It's no in making muckle mair;
It's no in books, it's no in lear;
To make us truly blest;
If happiness hae not her seat
And centre in the breast,
We may be wise, or rich, or great,
But never can be blest.
Nae treasures, nor pleasures,
Could make us happy lang;
The heart aye's the part aye
That makes us right or wrang.
Then let us cheerfu' acquiesce;
Nor make our scanty pleasures less,
By pining at our state;
And, even should misfortunes come,
I here wha sit hae met wi' some,
An's thankfu' for them yet.
They gie the wit of age to youth;
They let us ken oursel;
They make us see the naked truth,
The real guid and ill.
Though losses and crosses
Be lessons right severe,
There's wit there, ye'll get there,
Ye'll find nae ither where.

.—Burns (Epistle to Davie).

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The Artificial Feeding of Young Babies

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Unfortunately, all babies are not satisfactorily nursed; many are, doubtless, unnecessarily weaned. Some have to be weaned on account of the mother's ill health, some very few do not thrive satisfactorily on the mother's nurse and are greatly upset by it and many babies have to have supplemental feedings. If, however, the breast feedings were properly regulated and the mothers were more particularly instructed about their diet, rest, daily routine, proper care and regularity in the babies' nursing, there would not be so many bottle fed babies and the bottle would be the exception rather than the rule. Many babies who are fearfully upset by the mother's milk can be made comfortable by having the mother omit certain things from her diet: sometimes milk, sometimes eggs, sometimes bread, oatmeal, fruit juices, rarely vegetables. One can ascertain by performing protein skin tests on these babies just what articles in the mother's diet may be upsetting them. Doubtless, many babies who have been weaned might have been kept on the breast if one went to the trouble of doing protein skin tests. The late Dr. Sedgwick, of Minneapolis, was responsible for a movement which spread all through the middle western states: a movement in which questionnaires were sent out to all nursing mothers asking them to report their difficulties re the nursing of their babies. Later they were communicated with, and directions and every encouragement given to them to nurse their babies so that bottle babies become the exception in that region of the United States. It is not my purpose here to go into the subject of breast feeding nor to outline methods and means by which we can keep 90% or more of babies on the breast but to briefly enumerate the various methods which we have at our disposal for altering and modifying cow's milk to make it as suitable as possible for the nourishment of these babies who have been deprived of their natural heritage, mother's milk.

There are only two substitutes for mother's milk, namely, cow's milk and goat's milk. Goat's milk is more like mother's milk than any other milk but it has its drawbacks and is very difficult to obtain except during a few weeks each year, and then only in small quantities in any community, so that cow's milk has become the universal food for babies. Every food that babies are fed whether modified in the home or in the factory or a patent food, all either contain milk or have milk added to them sometime in their preparation.

Cow's milk in chemical composition, physical properties, etc., differs greatly from mother's milk and unless it is modified in various ways it is most unsuitable for the digestion of the average infant, although some few can tolerate it only slightly diluted, at a very tender age. It contains about the same amount of fat as does mother's milk but the fat globules are much larger and there are more volatile fatty acids. The sugar is the same in both, sugar

of milk or lactose, but there is less of it in cow's milk: 7% in mother's milk and 4% in cow's milk. The protein or curd is quite different in the two: in mother's milk there is a small amount of casein (.75%) and this small amount of casein forms fine flocculent curds in the baby's stomach; in cow's milk there is a large amount of casein (3%) which forms large, tough, cheesy like curds in the baby's stomach. Mother's milk contains about 1% of lactalbumin or whey protein. cow's milk contains about .5%. The salts of magnesium and calcium predominate in cow's milk, sodium and potassium in mother's milk. Cow's milk is acid and mother's milk is alkaline. So that one can readily see that there are vast differences in the two milks. The buffer value of cow's milk is greater than that of mother's milk. While more acid than mother's milk it is less acid really, because of the power it possesses of binding three times more acid than mother's milk. The buffer substances in cow's milk are the phosphates and the calcium caseinate (curd and calcium). It is very important to remember this because some of the methods of modifying cow's milk are based upon this difference in the buffer value of the two milks. This difference is thought now to be one of the great reasons why cow's milk is not so suitable as mother's milk. The great demand it makes on the acid of the stomach, neutralizing the hydrochloric acid and preventing the stomach contents from becoming as acid as in the case of mother's milk, causes the stomach to empty more slowly; the bactericidal action of the gastric juice is lost and the stimulus to the bile and pancreatic secretions is impaired, even entirely lost.

Now let us consider the many methods which have been adopted to render cow's milk more suitable for the infant. I shall deal principally with the more modern and recent methods of treating cow's milk, but in passing one might briefly mention some of the older methods.

In the last ten or fifteen years the feeding of infants has advanced by rapid strides, but we still have a great deal to learn, some of our methods are quite empirical but many of them are quite scientific; although at the first glance it might appear that some of the formulae were not so. Fifteen years ago percentage feeding was the method pretty well adopted in the feeding of young infants. The milk from the top of the bottle was used along with the skimmed milk, sugar of milk and lime water; sometimes top milk was used with whey: the so-called cream and whey mixture. It was possible by knowing the percentage of the cream (16%) which was used and the total amount of the formula, to calculate the percentage of fat in the day's food. This was kept down to 2 or 2½% for younger babies and gradually run up to 3½ or 4%. The casein was cut down by diluting the formula with lime water, or plain water, or by using whey instead of skimmed milk, so that the baby would get only the casein which was present in the cream. The amount of sugar in the milk and skimmed milk was calculated and sufficient sugar of milk was added to bring the percentage up to 6 or 7%. Babies were given different amounts of food at different ages. The casein was kept low for the young infants and a higher percentage was given for the older infants. The sugar was given in about the same percentage for all infants. It was thought that casein was the main cause of digestive disturbances, so that it was diluted or almost entirely left out of the formula by using whey, or it was rendered more digestible by adding lime water. The addition of lime water was about the only attempt that was made to render the formulae more digestible. It was thought that fat, provided it was kept around the same percentage as

in mother's milk, could be readily digested by most babies. Sugar was not thought to cause much trouble. Dr. Rotch, of Boston, was the originator of this method of feeding and all those who followed his method were very careful to feed the babies of certain ages certain quantities of milk of certain definite percentage, but they failed to realize that babies differed vastly in the digestive capacity and that even though the formula was modified to be similar to mother's milk, yet the fat was different, the salts were different, and the babies might be intolerant to fat in any quantity, or might be absolutely intolerant to sugar of milk or any sugar. These formulae were persisted in, in spite of the babies having digestive disturbances, because so many babies did very well on them: that is, babies who had a good tolerance for fat and for sugar of milk. Cards were carried around in the pockets of physicians with all sorts of scales, percentages, methods of measuring and calculating out the formulae and it was thought that an error of .5% one way or the other in either fat or protein would be a grave error and that if a baby were a certain age and were upset on a certain formula that surely it could not be the formula, because it had the proper percentage of fat and sugar and casein for a baby of that age. The percentage method is rarely used now because of the great troubles and difficulties in connection with the calculating of these formulae in the first place, and also because babies do equally well on formulae calculated in more simple manner; and also because of the great number of bottle babies who cannot tolerate fat unless it is specially treated. Whereas in the past every effort was made to have the formula resemble, in percentage, mother's milk, now we worry very little about the percentage of the different ingredients but we make the formulae as digestible as possible, realizing that it is impossible to make them at all like mother's milk. We also try to suit the formula to the baby, realizing that babies fall into certain types or groups, some do well on one type of formula, some do well on another type; some cannot tolerate fat at all, some cannot tolerate sugar, even in any percentage.

The present day tendency is to make all the components of baby food as digestible as possible; to alter, remove or replace those which cannot be digested or tolerated. Rather than think of percentages we think of digestibility of the food and babies' ability to gain and thrive and be comfortable, even though our mixture resembles mother's milk very little. We realize that fat and sugar are very great sources of trouble, and casein rarely: practically never when properly treated. We also know that the salts of milk may cause trouble. We know that fat, fermenting in the intestine, and sugar fermenting, cause diarrhoea with greenish, f r o t h y, scalding stools, even though they are present in the same percentage as in mother's milk. We know that casein, if properly treated, is very digestible but frequently binding. We know that casein is non-fermenting. We know that starches may ferment, that some sugars cause vomiting in certain babies, that some sugars are less apt to ferment than others. That fat sometimes does not ferment but is poorly absorbed and causes putty coloured stools with a failure to gain.

We are not without our methods of calculating the amounts of milk, sugar, fluids, etc., but these occupy a very secondary consideration. We pay much more attention now in cases where the baby is not thriving to baby's general condition. We first see that our formula is a well prepared, properly modified mixture, one which we think ought to suit that particular baby, and before making very radical changes in the food, if baby should have a digestive

upset, we look for a possible source of the trouble in the urine (Pyelitis), in the ear (Otitis), in the nose and throat (Nasal Pharyngitis), or we take the blood for a Wasserman, or we do a Von Pirquet skin test.

Let us now deal with the many ways of treating cow's milk to make it more digestible.

1. To render the casein or curd more digestible.

(a) Boil the milk three minutes.

(b) Add lime water or sodium citrate.

(c) Add barley water.

(d) Curdle the milk into fine curds with lactic acid, hydrochloric acid or lemon juice.

(e) Use of powdered milk, klim, dryco, lactic acid milk.

(f) Use of dextri-maltose sugar.

(g) Use of butter milk.

(h) Dilution with water.

2. To render the fat more digestible, or measures adopted when fat intolerance present.

(a) Boil the milk and omit the sugar.

(b) Use non-fermentable carbohydrate, dextri-maltose No. 1, corn syrup, barley or wheat gruel or cornstarch.

(c) Add powdered casein or casec to the formula.

(d) Use protein milk (powdered preparation containing a high percentage of casein, a low percentage of fat, low sugar and low whey salts. Our great weapon in all fermentative diarrhoea and summer complaint. This preparation is also acidulated and contains live lactic acid organisms).

You will see that certain methods of modification have an action both on fat and the casein; for example, adding lactic acid to milk makes the fat more digestible and also prevents the casein forming large junket-like curds. As soon as lactic acid is added to the milk, fine casein lactate curds form which remain in a fine state in the stomach.

In the average healthy baby a simple dilution of boiled milk and water with granulated sugar added is all that is necessary in order to enable baby to gain satisfactorily.

Now then, how can we scientifically construct a formula for a baby with a normal digestion? Let us take, for example, a baby weighing 12 pounds, age 3 months. It has been estimated that the average baby requires:

(1) One and one-half ounces of milk per pound, body weight.

(2) That babies under 10 pounds require 1 ounce of sugar, and over 10 pounds, 1½ ounces.

(3) That a baby usually requires 2 ounces more than its age in months per feeding.

(4) That 4-hour feedings, six feedings before three months and five after are sufficient.

Therefore, amount of milk equals 12x1½ equals 18; amount of sugar equals 1½ ounces or 3 level tablespoons; amount at feeding equals 3 plus 2, equals 5 ounces; total amount of food equals 5x5, equals 25 ounces.

Water therefore would be 25—18, equals 7 ounces.

Formula would be, 18 ounces of milk, 7 ounces of water—boiled 3 minutes.

Three level tablespoons of granulated sugar.

Total 25 ounces.

Make up with water if necessary.

Feed 5 ounces q.4.h. at 6, 10, 2, 6, 10 or 7, 11, 3, 7, 11.

This formula can be further checked by the use of calories: 18 ounces of milk contains 18x20, or 360 calories; 1½ ounces of sugar contain 1½x120, equals 180 calories, total 540 calories.

It has been estimated that average babies of that age require about 45 calories per pound. Five hundred and forty divided by 12 equals 45 calories.

One does not necessarily go into these calculations always when constructing a baby formula, but they are very simple, readily memorized and much more scientific than the

old percentage method of calculation.

If desired, this formula may have lactic acid added: 40 drops to the pint; or barley water may be added in place of water, or any other sugar may be added.

Unfortunately, all babies do not thrive well on this simple mixture even though it is curdled with lactic acid. It is for these babies that special formulae or special sugar are used. I shall take up a few of these formulae and their indications:

1. **Thick Cereal Feeding**, using 28 to 30 ounces of skimmed milk, 8 tablespoons of cream of wheat, 2 tablespoons of granulated sugar, 2 tablespoons of corn syrup.

This food is cooked for a couple of hours or until thick in a double boiler. The sugars are added later. It must be very thick so that it will adhere to an inverted spoon.

Indications: Pyloric Stenosis or Spasm, and particularly difficult feeding cases with vomiting and in some cases without vomiting, where failure to gain is marked.

2. **Butter Flour Mixture**, made from butter, granulated sugar, flour, water and milk. The butter is melted slowly over a low flame to drive off all the volatile fatty acids because it is these volatile fatty acids which constitute the part of cow's milk fat to which babies are intolerant. The flour is gradually mixed into this butter, then the hot water and sugar are gradually added while constantly stirring. The mixture is cooked for one-half hour and skimmed milk or whole milk added. This is a very concentrated, rich food which contains the fat of cow's milk, minus the volatile fatty acids. It resembles mother's milk in three very important points: first, it is rich and concentrated. Secondly, it is very digestible. Thirdly, it makes about the same demands on the hydrochloric acid in the infant's stomach as does mother's milk, that is, it has the same buffer value.

Indications: difficult feeding cases, prematures and supplemental feeding of breast fed babies.

3. **Protein Milk or Albumin Milk**: This is made from junket, from which the whey has been removed, and buttermilk. The junket is forced through a sieve and mixed with the butter milk. It contains a very high percentage of casein but the casein is in very fine division. It has little sugar and little fat and the whey salts are diluted. Everything in it is against fermentation and favours non-fermentation, thus tending to produce constipation.

Indications: diarrhoea due to sugar or fat fermentation, dysentery, summer complaint, some cases of vomiting. Its greatest usefulness is in those cases which tend to have green, curded, fermenting, scalding stools.

Let us take up briefly the indications for the various carbohydrates. Strangely enough, granulated sugar has been found to be more suitable for the average baby than any of the other sugars. Sugar of milk is probably better tolerated when baby vomits. Dextri-maltose is useful in cases of diarrhoea to add to boiled milk gradually or to protein milk, after the motions have become dry and pasty. It does not ferment as readily as granulated sugar. Dextri-maltose No. 3 is, however, laxative; it has potassium bicarbonate added to it. Dextri-maltose is partly starch and partly sugar and has somewhat the same effect as barley water on milk, in that it prevents tough curd formation, but it is also a very useful, nourishing sugar. Corn syrup is a very nourishing sugar, it contains glucose, saccharose, and maltose, and is useful in diarrhoeal cases. Malt soup is a laxative form of malt which is used in cases of constipation. Sugar of milk or lactose is a laxative sugar. Of the starches, barley, wheat and cornstarch tend to be binding, oatmeal and groats laxative.

I think, before terminating this paper, it would be wise to mention the role played by vitamines in infant feeding. We know that boiled milk, pasteuried milk, canned foods, have very little vitamine C. which tends to prevent scurvy, and even fresh milk may not have very much vitamine C. But even though food may contain some of the vitamine it is a pretty well recognized rule now that all bottle babies should have orange juice or raw tomato juice in gradually increasing quantities: not for its effect on the bowels but for its vitamine C. or anti-scorbutic content. All bottle babies must also have cod liver oil during the fall, winter and spring, particularly on account of its anti-rachitic content or vitamine D. The lack of sunshine during the winter, or to be more specific, the lack of ultra-violet rays in the sun, and the small portion of the body which the rays come in contact with during the winter, necessitate some substitute; cod liver oil and sunshine (ultra-violet ray) have the same effect: both of them prevent rickets and tetany.

Etiology of Headache

G. Peritz (Med. Klinik, August 5th, 1927, p. 1169) classifies the causes of headache as organic, including cerebral tumours, meningitis, hydrocephalus and syphilis; and secondly, functional disturbances, such as overwork, fatigue, anaemia, gout, endocrine irregularities, obesity, intoxications and reflected pains.

In the first group the pain is not localized but distributed over the head, sometimes beginning suddenly with intense severity. It depends on the sudden or gradual (in case of tumours) increase of the intracranial pressure; sooner or later the signs of intracranial disease become manifest and are diagnosed. This form of headache is often relieved by the lumbar puncture performed for aid in diagnosis. The headache of syphilitic origin is of two kinds: the one markedly localized in the bones and periosteum, and often the result of irritation of the nerves of the meninges. The other form is indistinguishable from functional headache, and probably also arises from a slight degree of meningitis. Functional headaches are myalgic and not of cerebral or meningeal origin. Myalgia is a partial muscular contraction, and the degree of pain is inversely proportionate to the resistance of the nervous system. The muscular contraction causes a production of lactic acid which, if the oxygen supply is insufficient to convert it into glycogen and carbonic acid, is not removed from the muscle and myalgia results. Fatigue after walking is due to the excess of lactic acid produced in the muscles. The headache of fatigue and overwork is the result of excessive production of lactic acid in subjects of poor muscular development.

In anaemia the diminished haemoglobin content of the blood causes deficiency of the supply of oxygen to the muscles, and an accumulation of lactic acid. Similarly in gouty persons the myalgia is caused by uric acid, the normal removal of which is interfered with, inciting contraction of the muscular tissues and myalgia.

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The Place of the Public Health Nurse in Epidemiology

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The field of public health nursing is every day broadening, and in no field is any more interesting and more worth-while work awaiting the nurse than in the field of epidemiology, and in no field is the nurse's training in careful observation of symptoms more valuable. The aim of the present paper is to indicate some of the ways in which the services of the public health nurse may, with excellent results, be utilized in this field.

Epidemiology is the "science of epidemic diseases," and it is usually thought of in connection with diseases caused by living organisms capable of rapid multiplication in the human body and with those diseases which, by analogy, are assumed to be due to similar organisms, though the definite organism has not yet been isolated. To this group belongs German measles, to which disease we shall give special attention today, as affording an example of the nurse's work in this special field.

In dealing with communicable diseases the epidemiologist has three objects:—

1. To prevent the spread of disease—with its consequent untimely death or serious complications or sequelae and consequent physical or mental handicap.
2. To minimize the loss of time to all involved—both the patient and contacts.
3. To minimize the expense—to the patient and contacts, and to the state.

The field epidemiologist is concerned in studying every aspect of each epidemic disease, thus gathering data which will establish such facts as:

1. Source of infection.
2. Earliest signs or symptoms of the disease.
3. Period of infectivity.

The information thus gathered will assist materially in the early detection of cases, and also reduce to a minimum the isolation period for the patient and the quarantine period for contacts—and both without endangering the public.

When the epidemiologist has made his study and carefully tabulated his data, and periods of isolation and of quarantine have been fixed by public health authorities, it remains only to carry out such routine measures as:—

1. Securing data on each individual case, as a means of gaining new information regarding any particular disease.
2. Instruction of the patient or of those in charge of the home as to isolation measures.
3. Observation and instruction of contacts and the tracing up of contacts.
4. Release of patient from isolation, instruction in regard to terminal disinfection, etc.
5. Diagnosis of the disease looked for in contact cases.

In each of the above measures the services of a trained nurse-assistant may be used to advantage. In the last-named measure—the diagnosis of positive cases of the particular disease in contacts—I know that many physicians will say that nurses must under no circumstances make a diagnosis, and yet in many cities a sanitary officer (not a medical man) visits the homes, and in such "routine" cases his diagnosis is accepted without question; the school teacher or the school nurse may make a tentative diagnosis, re-

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ferring the patient to the family physician; so the nurse-assistant to the epidemiologist may make her tentative diagnosis in just the same way, the individual case being always referred to the family physician, and any case exhibiting any irregular symptoms referred immediately to the medical health officer.

Rather than deal at any length with generalities, I shall give you an account of the measures taken in a recent epidemic of German measles in an attempt to control the epidemic among the students in the University of British Columbia; indicating the work of the nurse, as well as additional ways in which nurses might have been used if available; and also showing the results obtained from measures which were quite a departure from the routine quarantine and isolation measures.

During the first five months of the present year, January to May inclusive, there was an epidemic of German measles which seriously affected the school population of Vancouver and the neighbouring municipalities. The last epidemic of German measles in Vancouver had occurred during the winter of 1923-24, and as it was one which did not assume very large proportions, there therefore existed a large student body relatively non-immune to German measles. The epidemic started in the city schools in January, but apparently no cases occurred amongst the university students until the latter part of January, and no case was reported until the third week in February.

As soon as the presence of the first case of German measles and rumours of other cases in the university student body became known to the Campus Health Officer, Dr. H. W. Hill, Professor and Head of the Department of Nursing and Health, and Professor of Bacteriology, he at once took steps to attempt as far as possible to control the situation. This was, of course, no serious epidemic where fatalities might occur; even serious complications or sequelae were unlikely, unless the eyes should be seriously affected; **time** was the chief consideration. The spring examinations were only seven weeks away, and loss of time due to an attack of the disease (the Provincial Health regulations placed the isolation period at 14 days) or loss of time to a student who should be placed in quarantine as a direct contact (this period set by the Provincial Health regulations as three weeks for non-immunes), loss of time from either cause, i.e., isolation or quarantine, was a very serious consideration indeed to the university student.

In order to explain certain difficulties of the situation, it should be mentioned that the new University of British Columbia site is some seven and a half miles from the centre of the city, and over three miles even from the nearest city boundary. The Municipality of Point Grey adjoining the city separates the university lands from the city; it is "unorganized territory" and under the authority, therefore, of the Provincial Health Officer. The Campus Health Officer is in complete charge of all health matters within this whole unorganized area, and in particular may make, with the approval of the Provincial Health Officer, such health regulations as he may see fit to govern students and staff while within the University Reserve district. As there are no university dormitories, however, at the close of the day the whole student body, 1,591 in number, scatters: some going by private motor or motor bus and street car to their homes in the city or in the surrounding municipalities (1,050 of the students are of this group), while the remaining 541 live in private boarding houses or in fraternity houses, a fairly circumscribed boarding-house district having grown up in

the Point Grey Municipality. The difficulty of keeping under supervision such a scattered population was the greatest obstacle in putting any regulations into effect and required special arrangements.

The Campus Health Officer, with the approval of Dr. H. E. Young, the Provincial Health Officer, put into effect regulations which he had already experimented with on a large scale in the army, i.e., a plan of daily observation of contacts instead of quarantine, and also a shortened period of isolation for the actual case, cutting the time in half by reducing the isolation period from 14 days to seven full days. Lest the situation should get out of control, the understanding and co-operation of the students had to be obtained; and it seemed well worth while to try the plan as the epidemic furnished an opportunity for further experimentation, which, if successful, would establish methods which would make it very easy to handle the situation should other diseases of a more serious nature at a future time occur.

The plan necessarily developed rapidly, as the first reported case of German measles was a student living in a fraternity house where there were **thirteen** other students. The student was sent at once to the City Infectious Hospital. Later in the day another case was reported from the same house, and rumours were heard of students, who had been observed to have rashes, who had been away for a few days and then returned to the university, and so on. Apparently already the seeds of the epidemic were sown. The fraternity house was visited; the other rumours were investigated and the names and addresses of contacts obtained.

As director of the Vancouver Hospital Laboratories, at the university only half of each day, the campus health officer naturally could not attend to much of the detailed work in connection with the epidemic; provision to meet the emergency must be made and regulations must be made known at once to the student body. Dr. B. Blackwood, the health officer of the municipality of Point Grey, was appointed assistant campus health officer and placed in charge of all visits of inspection of contacts in the Point Grey district. The resources of the Nursing Department were drawn upon for the routine work in the university itself; the writer undertook the observation of all suspicious cases, the keeping of detailed records and the release of cases; while the clerical assistant in the department took charge of the reporting of all cases to the Provincial Health Department and the notifying of the Vancouver City Health Department and the health departments of neighbouring municipalities of students from homes in the various districts who had developed German measles, noting especially the fact of other contacts in the home of children of public or high school age. There was also the disposal of any cases developing during the day, which could not be permitted to return home in the crowded 'bus or street car, while the use of an ambulance at one dollar per mile (with students to be conveyed from two to fifteen miles) was practically prohibitive. To overcome this difficulty a student ambulance service was organized—and it might here be mentioned that so excellent was the technique observed by office assistant and student ambulance driver, both exposed many times very directly to infection, that, though both were non-immune, neither developed the disease.

Having arranged for the personnel to carry on the work day by day during his absence from the university, steps were taken by the campus health officer to inform the students of the plan. This included giving the data necessary for the understanding of the nature of the disease, and the probable method of infection, and acquainting them with

the regulations regarding the observation of contacts which was to take the place of quarantine. This was done through the student publication, the "Ubssey," and the regulations which went into effect were, briefly:—

1. That each student upon **release from isolation** from an attack of **any** infectious disease, including German measles, must report immediately upon return to the university at the Department of Nursing and Health, in order to secure a certificate **which** would enable him to return to classes.

2. That during the prevalence of German measles, **all** students who had not attended classes for **two days or more** must upon return to the university report immediately to the Department of Nursing and Health, where again a certificate would be given enabling them to return to classes.

3. That all students (not previously immune), who, because of **exposure** to German measles would ordinarily go into quarantine, will be placed under daily **observation**, not during the whole three weeks (as given in the Provincial Health regulations) but **from the 14th to the 21st day after exposure**, during which period, if not immunized by a previous attack, they may come down with the disease at any time, and if they do, may at once infect other people.

4. This **observation** will consist of a daily inspection by the assistant campus health officer. This daily inspection will be carried out at the students' homes (if in the Point Grey area) in time for the students, if clear, to attend their classes. Students residing in Vancouver must make similar arrangements with their family physician or other person, such as a city public health nurse (which reports must be recorded with the campus health officer) or else go into quarantine from the 14th to the 21st day.

Following the first case, no further students were sent to hospital, but were cared for in their homes or boarding places, and special mention must be made of the very excellent co-operation which was received from those who had taken students into their homes to board, in caring for the students as well as enforcing isolation. The very splendid co-operation of the whole student body must also be here recorded. While, as mentioned at the outset, there were undoubtedly several "missed" cases, and many cases who at first had gone back and forth in the crowded 'buses — not aware that they were exposing others to infection — yet with few exceptions the most excellent co-operation was obtained from the students. They indeed assisted in the early detection of many cases, and through their intervention other conditions, especially skin lesions, were brought to light and the students concerned advised as to the benefits of securing the necessary treatment.

Many students visited the office to report symptoms which they feared might be suspicious, and others indirectly exposed to infection in class rooms or campus reported for inspection from the 14th to the 21st day as in the case of the more direct contacts in the homes. No student found it necessary to undergo a quarantine period in order to comply with the regulations. Students living in the city proper, or at a distance, were able to arrange with private physicians for inspection; others arranged for some student with a motor to drive them out to the university, when they at once reported for inspection at the Nursing and Health Department (over 30 contacts were inspected in this way during the quarantine period, i.e., the period in which they were likely to come down with the disease). The object effected was, of course, to keep each contact under expert supervision during the danger period, that chance infection of the

group at large in the crowded 'buses might be avoided. Should the rash occur during the day, the student at once reported to the department where provision was made to send the student home by the ambulance service, thus again limiting the number of contacts.

During the weeks of the epidemic, 192 cases were recorded. In the cases reported at once to the nurse assistant a record of the symptoms observed was made; in the cases visited by the assistant health officer or by private physicians, or not seen by a physician, notes, necessarily less accurate in detail, were made when the student reported for a certificate of release.

Forty-three cases were seen in the Nursing Department on the day the rash developed, of which some five or six had been under observation for several days. Of this number the writer was particularly interested in noting the marked glandular involvement on the day of the rash, and in a few cases noted, and in many of the histories obtained note of, glands in cervical, mastoid or occipital regions as early as six days before the rash appeared; swelling in sublingual glands was noted in two cases, and in one was still present on return on the eighth day; a macular rash on the soft palate, showing even before the rash was plainly perceptible on face and neck, was also of interest. The fact that the rash was often well marked on chest and shoulders, while only very faintly showing on neck, face and forehead, and also the very transitory nature of the rash in some cases, might very easily account for several missed cases.

Of the 43 cases observed on the day of the rash:

31 cases showed involvement of mastoid, occipital, cervical, sub-lingual, or submaxillary glands;

2 cases no glandular swelling was observed;

10 cases—earlier cases—no record made of glandular involvement;

3 cases under daily observation before rash appeared, glandular involvement was noted for three, four and five days, respectively, before the appearance of the rash;

2 cases under observation day before rash appeared, glandular swelling noted for one day;

6 cases reported glandular swelling noted for periods varying from two to six days, the time being quite definitely fixed in each case;

20 cases glandular involvement noted on day of rash, not noted earlier by the student, and students not previously under observation.

In 16 cases there was a slight elevation of temperature on the first day of the rash, varying from 99° to 99.8°, in only one case did the temperature reach 100° on that day.

In the remaining 149 cases, on reporting at the end of the isolation period, practically every case had noted glandular involvement, and in many cases students stated they had observed it for several days before the rash appeared.

Many questions suggested themselves to the writer, but one of especial interest, owing to the early involvement of the lymphatics, was whether the infection was transferable before the appearance of the rash. No case pointed definitely to a shorter incubation period than 14 days, though in one house (the first fraternity house under observation), contact cases in the house developed the rash within six, eight and ten days. However, since a second case developed on the first day, a common "missed" source of infection must be granted; in two other cases the rash appeared on the eighth day, yet the possibility of earlier sources of infection could not be eliminated; in other cases the period was from the 14th to the 22nd day.

Is it possible, however, that the incubation period is longer than the 14 to 21 days usually given, and that the period of infectivity dates from the very earliest symptoms of glandular involvement, dating as noted five or six days before the appearance of the rash? This is, of course, a question for the epidemiologist;

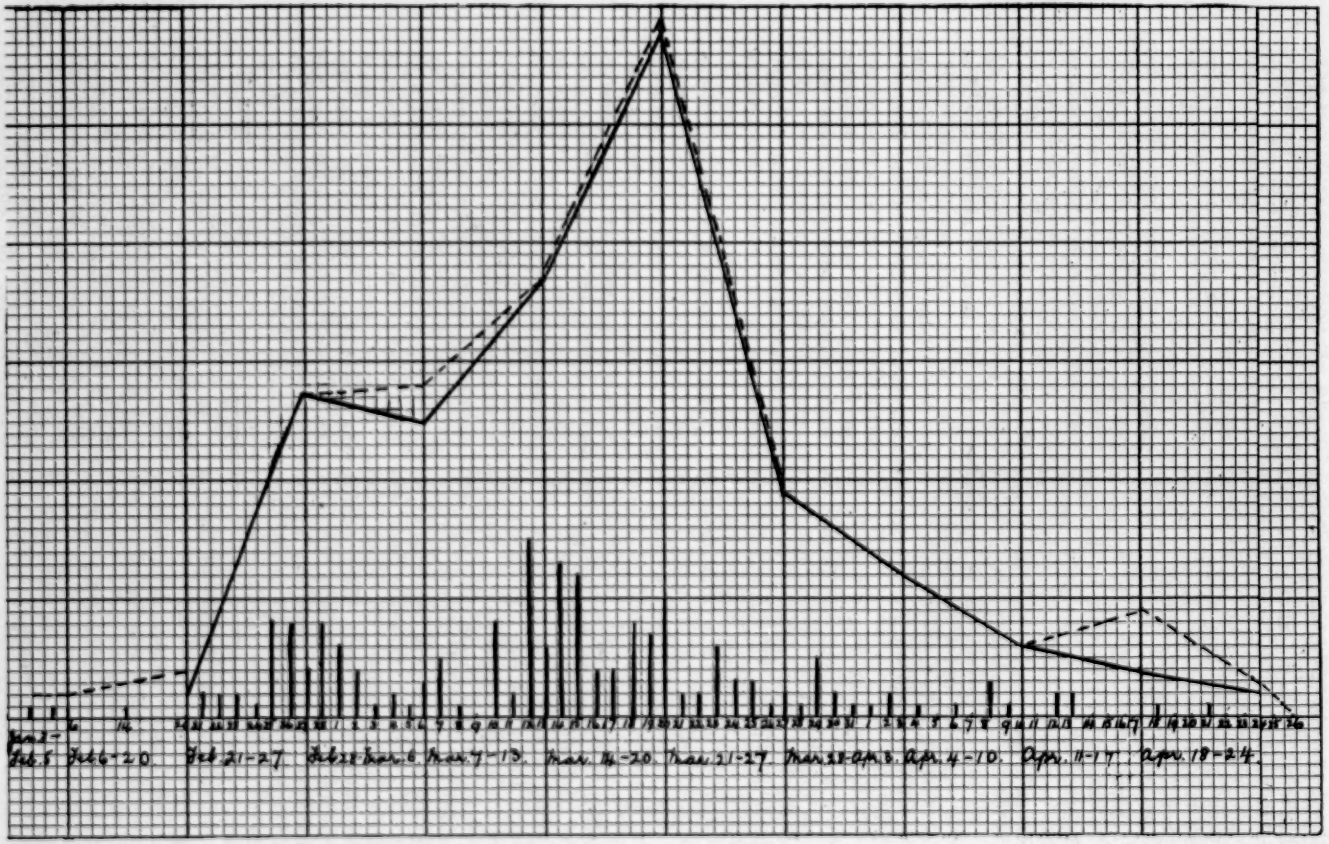

Chart indicates cases of German measles day by day and week by week. The dotted lines indicate corrections resulting from cases discovered from doctors' certificates at close of term: exact dates of rash being uncertain these results are indicated only weekly, not daily.

the public health nurse can only assist in securing the data. The large number of cases in which the eyes were affected is also worthy of note.

A tabulation of the cases according to year and faculty showed very little variation in the percentage affected; i.e., in the groups varying from 16 to 22 or 23 years, all ages proved equally susceptible. A checking up at the end of the term of doctors' certificates sent in to the offices of the various deans revealed seventeen additional cases. Five of these had occurred during January, thus forming, in part at least, the source of the epidemic, since there had been no control of their release from isolation and no checking up of contacts, and seven cases occurred at the close of the term, during the examinations. Since these did not return to university they were not, therefore, a source of infection to other students. In all, 192 cases reported to the Nursing Department; with the 17 additional cases referred to, this made a total of 209 cases—13.1% of the student body.

The attached diagram very clearly indicates the course of the epidemic—the rapid spread from the early missed cases, 27 cases developing during the first week of the recognized epidemic (i.e., due to missed cases of 14 to 21 days earlier), while during the third week the number rose to 58. This was the peak of the epidemic. The numbers then fell by rapid lysis during the remaining five weeks of the term; that is, once the cases were isolated for the full period of seven days, and contacts under supervision (though daily attending lectures), cases were detected very early and the epidemic at once controlled.

A detailed study of the 192 reported cases and the resulting contact infection is of interest. It must be remembered, of course, that the possibility of chance infection in street car, bus, class room, campus, etc., cannot be eliminated. In cases (as in the first fraternity house), where early cases occurring within a few days of each other evidently arose from the same source, such have not been included as resulting from the cases under isolation.

In 115 cases there were no student contacts in the homes. In the remaining 51 cases there were five concurrent cases of infection; i.e., not cases of contact infection from the known sources, and 21 developing cases as indicated below:—

	Homes and cases.	Student contacts in each home.	History of immunity from previous attacks.	Cases of concurrent infection.	Remaining susceptible cases.	Number of cases developing.		Percentage of susceptibles developing disease.
	34	1	10	2	22	5		23%
	9	18	3	....	15	3		20%
	1	3	....	....	3	1		33%
	4	20	1	....	19	6		32%
	1	8	....	....	8	....		.....
	1	9	....	....	9	3		33%
	1	13	....	3	10	3		30%
Totals ...	51	72	14	5	86	21	Average	24.4%

While the results are not altogether satisfactory, 24.4% of susceptible contacts appearing a high average infection, yet it must be borne in mind that the 51 cases from which the infection developed were cared for in boarding houses, and the group concerned being a student body, strict isolation measures may not always have been observed, and there was the further chance of contact infection from unrecognized cases. The record of the home in which there were eight contacts and in which no new cases developed

was a splendid example of what can be done. The only group with which we can compare results is with the public and high school population of Vancouver and Point Grey; while the groups differ somewhat in age, yet the relative percentage of immunes probably varied very little:--

	Percentage of infection.	Loss of time to contacts through quarantine.
University students	13.1%	No time lost.
Point Grey High School students	13.5%	2 weeks for each contact.
Point Grey Public School students	21.2%	2 " " " "
Vancouver High School students..	3.9%	1 " " " "
Vancouver Public School students	12.1%	1 " " " "

(In the Vancouver public schools the percentage of the infection varied from 1.2% in one school to 28.3% in another school, and all the way between.)

The results obtained among the university group do not compare very favourably with those in some of the high and public schools, though the total results are approximately the same, but it is to be remembered that there is as yet no health service in the university; this was just an emergency measure to meet an epidemic, while the Medical and Nursing Service in the Vancouver schools was organized some 17 years ago. The work accomplished in some of the Vancouver schools alone is evidence of the success of the nurse in epidemiology.

The main purpose, in this partialone is evidence of the success of time to cases and to contacts:

In 192 cases there was effected a saving of 7 days each..... (By reduction of isolation period from 14 to 7 days.)	1,344 days
In 91 susceptible contacts a saving resulted of..... (By substitution of inspection for 21 days' quarantine.)	1,911 days
Making a total saving of	3,255 days or 8.9 years

Even reducing the quarantine period to seven days (as carried out in the city schools), thus reducing the time saved in the contact cases to 637 days, even this still results in a total saving of 1,981 days or 5.4 years of university students' time. Estimated in dollars and cents, at the most conservative estimate of the potential value of student time, this would result in a large sum. Translated into the loss as recognized by the individual student in missing a week of lectures and laboratory work, the gain was well worth while.

The same method of observation of contacts in a limited number of cases of real measles and scarlet fever was successfully carried out, no new cases developing. The whole plan outlined hinges on the early detection of the first case and upon the most careful inspection of every contact. The study of individual cases and of contacts in the epidemic just described emphasized to the writer the advisability of daily inspection of contacts rather than quarantine, both as a means of saving time and also of reducing the number of "missed" cases by the detection of transitory rashes and other signs easily overlooked by the untrained person. If it is a public responsibility to protect the public at large, in so far as it is possible, from chance contact with persons in the early, but infective, stages of acute communicable disease, only through the employment of a sufficient number of trained workers can such a programme as the one described be carried out. The public health nurse, with her knowledge of disease, her skill in the detection of symptoms, her accuracy in record-keeping, and her recognized place as a home visitor, presents herself as the assistant most economically available in numbers sufficient to carry out an adequate programme for the control of communicable diseases.

News Notes

CANADIAN NURSES ASSOCIATION

At a meeting of the Executive Committee, Canadian Nurses Association, held on October 27th, 1927, in Montreal, the following resolution was passed: Resolved at this the first meeting of the Executive Committee, since the death of their beloved President, Miss Flora Madeline Shaw, that the members of this Association desire to place on record their appreciation of the great contribution which Miss Shaw made to the nursing profession in Canada. Her qualities of leadership, high ideals and noble Christian character have made her honoured and beloved. Her loyal service and help can never be forgotten by all who have been associated with her for so many years.

The next biennial meeting of the Canadian Nurses Association will be held July 3rd to 7th, 1928, in Winnipeg, Manitoba.

Further information will be published next month.

ALBERTA

EDMONTON

Miss Eileen Whyte (University Hospital, Edmonton, 1926) has accepted a position on the staff of the University Hospital Clinic.

Mrs. T. H. Whitelaw is visiting relatives in Brussels and Guelph, Ont.

Miss Amy Conroy has gone to the School of Agriculture, Raymond, to teach Home Nursing and First Aid.

Miss Alice Watherston is spending her vacation at the Coast.

BRITISH COLUMBIA

The regular quarterly meeting of the Graduate Nurses Association of British Columbia was held in Vancouver on October 29th, 1927. The meeting of the Council and of the Committees on Nursing Education and Public Health took place in the afternoon while the general meeting was held in the evening.

Miss McLeay, who at the last annual meeting was elected convener of the Private Duty Committee, resigned the position on account of ill health. Owing to the illness of the convener no meeting of the Private Duty Committee was held, but a special meeting was arranged for November 14th, at 8 p.m., to nominate a convener for this committee.

The Nursing Education Committee meeting was well attended and very satisfactory reports were presented by conveners of committees who had been at work during the summer months. The committee with perhaps the greatest progress to report was that which had been working upon a standard form for use in the various training schools, which would adequately indicate the educational standing of applicants. All superintendents of nurses within the province had been consulted and a satisfactory form was agreed upon. Considerable work was done, too, upon means of evaluating the educational standing of applicants who could not produce certificates of two years' successful high school work but who apparently had educational qualifications to meet the required standards. A plan agreed upon was submitted along with the Educational Form, to the Nurses' Council for approval, with the suggestion that both be recommended for adoption by the training schools. Other committees at work upon outlines of study courses and still others upon new-type examination questions made their reports. It was arranged that these plans and questions should be sent to the training schools for approval.

The Public Health Nursing Committee elected Miss Sanders as vice-convener and also convener of the committee to arrange supper meetings in Vancouver during the winter. Miss Mary Campbell accepted the convenership of a committee to consider ways and means of starting a reference library for the use of the public health nurses of the province. Miss Elizabeth Breeze, chief school nurse, Vancouver, reported progress in arranging the permanent Public Health Exhibit and asked the co-operation of all nurses in this work. Miss Breeze, who received her diploma in Public Health Nursing from the University of California this year, spoke of the special features in the Public Health Course given at that university. Other speakers were Miss Harriet Jukes and Miss M. A. McLellan.

Miss Kathleen Perrin, industrial nurse with the British Columbia Telephone Company, gave an outline of her work. This is the first industrial nursing to be undertaken in British Columbia.

Miss Mirfield, convener of the Committee on New Office Accommodation, reported progress, but no definite arrangements had been made.

Miss K. Sanderson, convener of Committee on Changes in By-Laws, reported in full the changes recommended.

A recent report showed that only 10.6 per cent. of the membership of the British Columbia G.N.A. were subscribers to The Canadian Nurse. The following resolution was passed: "That the B.C. Graduate

Nurses Association in their quarterly meeting on October 29th, 1927, urge upon its members their duty as members of the Canadian Nurses Association to maintain an active interest and to assist in all undertakings of the Canadian Nurses Association. It also urged that the members should support The Canadian Nurse. This report should include sending in news items and articles of interest as well as subscriptions."

Miss Stuart, superintendent of the Royal Columbian Hospital, New Westminster, was appointed a member of the council, to succeed Miss K. Scott, who resigned owing to her residence now being in California.

Dr. J. G. Jarvis, of the University of British Columbia, gave an instructive illustrated lecture on the Relation of Government Inspection of Meat to Public Health.

VANCOUVER

Mrs. E. D. Calhoun, supervisor of the Victorian Order of Nurses for Greater Vancouver, has resigned her position and will leave shortly for California.

Miss Helen Munslow, of the Victorian Order of Nurses' staff, has resigned her position. It is more than a rumour that she is to be one of the participants in an interesting event in the near future.

Miss I. Jeffares, of the Cowichan Health Centre, has resigned.

Misses M. Claxton and Thatcher are on the staff of the Cowichan Health Centre.

Mrs. Lucas, for the past five years chief nurse at the Saanich Health Centre, has been appointed public health nurse at the University of British Columbia in connection with the Students' Health Programme.

Misses M. E. Morrison (Victoria) and I. Jeffares (Duncan) were visitors to the city during the autumn meeting of the B.C. G.N.A.

Miss Shand (Public Health, University of British Columbia, 1927) left recently for Toronto, where she has accepted a position with the Victorian Order of Nurses. Miss Shand will be very much missed by her many friends in Vancouver.

VICTORIA

St. Joseph's Hospital

Miss Florence Sehl, 1919, has been appointed matron of Cumberland General Hospital, Vancouver Island, where she has been on staff duty for the past five years.

Miss Grace Oliver, 1918, is taking a post graduate course in public health nursing at Firlands' Sanatorium, Seattle, Wash.

Miss Jean McEwan, 1920, is taking a course in interior decorating in a department store in San Francisco.

Miss Doris Lambert, 1923, is on staff duty at Campbell River Hospital, Vancouver Island.

Miss Janet McEwan, 1919, has accepted a position on the staff of Stanford Hospital, California.

Miss Phyllis Wightman, 1924, is supervisor of the operating theatre, St. Joseph's Hospital.

Miss Doris Taylor, 1921, is in Dr. M. T. Keys' office, Victoria.

MANITOBA

BRANDON

The regular monthly meeting of the Brandon Graduate Nurses Association was held at the home of Mrs. Lawson Ferrier. There was a good attendance and a very interesting address was given by Dr. S. J. S. Pierce on "Heredity." It was decided to publish a cook book and in this way raise funds for the Association.

Members and friends of the B.G.N.A. met recently at the home of Mrs. S. J. S. Pierce when Mrs. George Miller (nee F. Francis) was the guest of honour. During the evening Mrs. Miller was presented with a casserole from the nurses of Brandon.

Mrs. T. J. Wilson (Elizabeth Walker, Hamilton General Hospital) has accepted the position of nurse at the Industrial School here.

NEW BRUNSWICK

SAINT JOHN

Recently Mrs. Cecil J. Markham, formerly Miss Georgie Moxon of Saint John, held her post-nuptial reception at St. Thomas' rectory, Stanley, N.B.

Miss Jessie Murray (General Public Hospital, 1916) is confined to her home, 19 Harding Street, with a broken leg, the result of a motor accident in St. Stephen.

Mrs. Albert Goddard (General Public Hospital, 1913) has returned to her home in Edmonton, Alberta, after spending the summer with her parents, Mr. and Mrs. Jasper Cameron, in West Saint John.

Miss Agnes D. Carson, superintendent of the Children's Hospital, Halifax, has been visiting friends in St. Andrews and Saint John.

The October meeting of the Saint John Chapter of New Brunswick Association of Registered Nurses was held in the Nurses' Home, General Public Hospital, the evening of October 31st. As this was "Hallow eve" some of the members came in character dress. After the business was concluded, a social hour was spent and refreshments were served in "Hallow eve" style. The meeting was well attended.

ST. STEPHEN

Much sympathy is extended to Miss Ella McBean in the loss of her mother, to Mrs. Harold Beek in the loss of her mother, and to Mrs. J. Perley Mundie in the loss of her father, Capt. Frank Johnson.

A delightful Hallowe'en party was given by the nurses of the Chipman Memorial Hospital at the Robinson Memorial Home on October 31st.

NOVA SCOTIA

The graduation exercises of the Yarmouth Hospital took place October 11th, 1927, at the Nurses' Home. Mr. G. Prescott Baker acted as chairman and President A. H. Eakins presented the diplomas.

The exercises were opened with prayer by Rev. Mr. Chipman, followed by a musical programme. Mayor Kennedy spoke briefly and congratulated the graduates. Mr. Kenny, of the Victoria General Hospital, spoke on hospital work in its early phases and the value of training schools for nurses. Miss Mary Watson, superintendent, administered the Hippocratic oath to the graduates, after which the diplomas were presented as follows: Gertrude Mosher, Canso; Iris Rogers, Yarmouth; Olive Corbin, Halifax; Helen Margeson, Berwick; Isma Estabrooks, McAdam Junction; Bergina Bowman, Saint John; Mary Dallas, Glasgow, Scotland; Mary Hunter, Windsor; Hazel LeBlanc, Little Brook, Digby County; Estelle Foster, Aylesford, Kings County, N.S.

The annual graduating exercises of the training school of the Payzant Memorial Hospital were held Tuesday evening, October 25th, 1927, at the Nurses' Home. Mr. Otis Wack, chairman of the Hospital Board, presided. The assembly present included the medical staff, the superintendent and nurses, the parents and friends of the graduating nurses, the Hospital Board and the Ladies' Auxiliary. The speakers for the evening were Dr. J. W. Reid, representing the medical staff; Father Fleming for the ministerial body; Dr. O. B. Keddy for the town; Mr. Illsley, federal member, who represented the Dominion; Mr. H. W. Sangster for the province, and Mr. Otis Wack the board. The graduating class—the Misses Gladys Parker, Walton; Mabel Card, now in Bridgewater, and Susie Newcombe, Hantsport—were presented with their diplomas and pins by the chairman, and the Ladies' Auxiliary gave to each graduate a bracelet and brooch to match. At the close refreshments were served by the members of the Auxiliary.

Miss Margaret Macdonald, of Pictou, N.S., matron-in-chief of the Canadian Nursing Service during the war, was made honorary member of the National Council of Women at their annual convention held at Stratford, Ont., October, 1927.

Miss Janet A. Campbell, public health nurse for Hants County, successfully held a "Better Babies" contest at Windsor and Hantsport. Literature, diplomas, certificates and bronze medals were furnished by the "Better Babies' Bureau" of the "Women's Home Companion." At the close of the contest, Miss Campbell joined the Travelling Dental Clinic in West Hants County.

Miss Thelma Myers, formerly of the nursing staff of the City Tuberculosis Hospital, Halifax, has accepted a position on the staff of the Nova Scotia Sanatorium, Kentville.

Miss Evangeline Duggan, who has been visiting her parents at Halifax for the past month, sailed for New York, October 5th, where she has accepted a position on the staff of the Roosevelt Hospital.

Miss Boswell, of Ottawa, is in Nova Scotia on a tour of inspection of the various branches of the Victorian Order of Nurses.

The following nurses have returned from their vacations: Miss Gene MacDonald, from her home in Eastern Passage; Miss Mabel Brown, from Parrsboro, N.S.; Miss Sadie Archard, from Cape Breton; Miss Rita Daniels, from Lawrencetown; the Misses Alma Shrinder and Margaret McNeil, from Enfield.

Miss Kathleen Byrne has returned from Montreal and is planning to spend the winter with her parents, Dr. and Mrs. T. I. Byrne, Dartmouth, N.S.

Miss Margaret MacDonald and Miss Walker, of the nursing staff of the Harbour View Hospital, Sydney Mines, spent the month of October in Halifax.

Miss Edith I. Hamm and Miss Jean Thompson have returned to Boston, Mass., having spent the summer in Halifax.

Miss Violet Kirk, superintendent of nurses, Victoria General Hospital, Halifax, visited friends in Halifax in October. Miss Kirk shares with Miss Evaline M. Pemberton, formerly night supervisor at the V.G. Hospital, the distinction of having organized the Association of which the present Registered Nurses Association of Nova Scotia is the flourishing product.

Miss Rita Ritchie, graduate Waltham Hospital, Waltham, Mass., who has been visiting her parents, Dr. and Mrs. S. G. Ritchie, for the past two months, has been entertained at a number of delightful showers and teas in honour of her approaching marriage to Mr. David Hanson, of Waltham, Mass.

Miss Pearl Brennan, formerly a member of the nursing staff, Grace Maternity Hospital, and sister, Miss Anna Brennan, formerly of the G.H.H. nursing staff, left Halifax, October 1st. They expect to spend the winter in New York.

Miss Mary J. Hayden, superintendent of the Richmond Heights Health Centre, has returned to duty from a well-earned vacation, and Miss Norah E. Larkin, formerly

a member of the V.O.N., for the past two years a resident of New York, is visiting in Halifax.

ONTARIO

DISTRICT 1

Miss Mary Shand (University of British Columbia) is opening the new Victorian Order centre in the Border Cities, and Miss Jean Whiteford (McGill University) in Sarnia.

Three nurses who graduated in public health nursing from the Western University, London, are now with the Victorian Order: Miss Harriet Brydon in New Liskeard, Ontario; Miss Mildred Thomas in Barrie, Ontario; and Miss Margaret Millman in Pictou, Nova Scotia.

DISTRICT 2

Brantford General Hospital: The Alumnae Association held their monthly meeting on November 1st, in the Nurses' Residence. A letter was read re affiliation with the Canadian Nurses Association. After discussion the Association decided to apply for affiliation. At the close of the business meeting a social hour was spent and refreshments served.

Miss Margaret Tait, 1903, has accepted the position of superintendent of Galt General Hospital, Galt, Ont.

Miss Ida Martin has been substituting at Dr. D. A. Morrison's office during the absence of Miss B. Marshall.

Miss Hope Doeringer and Miss Anna Fair have been spending a few days in Detroit.

Miss Helen Potts has returned from Los Angeles and has been appointed assistant superintendent of the Brantford General Hospital.

Miss Edna Clarke has been transferred from New York to Simmonds College, Boston, Mass.

Miss Hilda Muir and Miss Blanche Gerhard have been relieving on the staff of the Brantford General Hospital for the past few months.

Miss A. Bartley, 1922, who has been supervising at Columbia Hospital, Wilkensburg, has returned and is doing special duty.

Miss Gera Forsythe's many friends will be pleased to learn that she has sufficiently recovered from her recent operation to return to her home in Toronto.

Miss Edmondson has been appointed assistant superintendent at the Clinton Memorial Hospital, St. John, Mich.

DISTRICT 4

District No. 4 of the Registered Nurses Association of Ontario was represented at The Welland House, St. Catharines, on Saturday, October 29th, 1927, by about seventy members from St. Catharines, Niagara Falls, Welland, Dunnville, and Hamilton.

Miss Buckbee, chairman of the district, in a brief address, expressed her appreciation of the hospitality and generosity of the St. Catharines nurses extended to the convention in May.

The secretary-treasurer's report was read, resolutions forwarded from the May convention dealt with, and reports of committees presented.

Miss Helen McDonald's report of the provincial meeting was read by Miss Moran.

Miss Allan read a short history of the life of the late Miss Shaw, who was president of the Canadian Nurses Association until her sudden death in August in Liverpool.

Miss Rayside so vividly described the dedication of the Memorial Altar in the Peace Tower at Ottawa that her listeners seemed to see the high tower, the decorated Altar, the Book of Remembrance, the light high up in the chamber, and the whole solemn ceremony, and to feel a new sense of loss, a new sense of the wonder of sacrifice, and a new hope.

After a short intermission, dinner was served, following which the guest of honour, Dr. Goldwin Howland of Toronto, gave a very interesting address on Occupational Therapy. Dr. Howland described the normal person as one who does things in a reasonable way, who can concentrate, and who controls primitive instincts. When people are ill they are not doing these, hence the balance is disturbed.

The hospital aide's training includes psychology and applied muscle movement. In the hospital the aide should live with the nurses, be under the head nurse, and receive the co-operation of the nurses. The aide, on the ward, must study the patients so as to get something to interest them. Because most people are artistic, the arts and crafts are emphasized. The patients must be encouraged to look forward.

Miss Elsley, teacher of occupational therapy at Hamilton General Hospital, cited several cases of patients whose dreary hours had been made interesting and cheerful by the application of the principles outlined by Dr. Howland.

After a hearty vote of thanks, moved by Miss Brewster, had been extended to Dr. Howland, and Miss Wright and all who had helped with the arrangements, the meeting was closed by the singing of God Save the King.

DISTRICT 5

Toronto

Grace Hospital: The November meeting of the Alumnae Association was well attended. Bishop White, of Honan, China, gave a most enlightening and interesting illustrated lecture on his work during thirty years in China. Arrangements were made to co-operate with the Neighbour-

hood Workers in the distribution of five baskets of Christmas dinners, and clothing for twenty-three children.

Miss Jean Elizabeth Weir has joined the nursing staff of the Red Cross Outpost, St. Joseph's Island.

Hospital for Sick Children: Miss Gertrude Evans, 1927, winner of the Alumnae Scholarship, and Miss Gertrude O'Hara, 1909, are enrolled for the Public Health Course at the University of Toronto.

Miss Mary Acland and Miss Lilian Horton, winners of 1927 scholarships, are attending the School for Graduate Nurses, McGill University, Montreal.

Miss Miriam Gibson, 1926, has recently taken over the duties of assistant instructor at the Hospital for Sick Children, Toronto.

Miss Ella J. Jamieson, associate director of school nursing service in the Ontario Department of Health, has been granted a travelling scholarship by the Rockefeller Foundation, and has left for Columbus, Ohio. She will spend several months studying health education in the larger cities of the United States. Miss Jamieson was president of the Graduate Nurses Association of Ontario for four years.

St. Michael's Hospital: The regular meeting of the Alumnae Association of St. Michael's Hospital Training School for Nurses was held in the Residence on October 24th, Miss Hilda Kerr, president, in the chair. It was decided to again offer prizes to the graduating class, intermediate and junior students, to be awarded at the graduation exercises in 1928, as was done for the past two years. Following the meeting the remainder of the evening was enjoyably spent at bridge.

The annual Requiem Mass for deceased members of the Alumnae was celebrated by Rev. Father Cantelon in the Hospital Chapel on November 3rd.

The marriage of Miss Aileen O'Connor, 1920, to Mr. Ernest Enright, was celebrated at the Church of St. Vincent de Paul, Toronto, Saturday morning, November 5th. Since completion of the Public Health Course, University of Toronto, in 1922, Miss O'Connor has been with the Victorian Order of Nurses. Mr. and Mrs. Enright will reside in Toronto.

Miss Margaret Nealon, 1922, has been appointed to the staff of the Provincial Board of Health and will take up her duties at Sudbury, Ont., in the very near future.

Toronto General Hospital: The Alumnae Association met in the Nurses' Residence on Wednesday, November 2nd. Following the regular business meeting Miss Ray, of the Toronto Public Library, spoke to the members, reviewing five of the best novels of the season. Miss Ray's address was much enjoyed and appreciated and the members hope to have an opportunity to hear her again. At the close of the evening refreshments were served.

Miss E. Wilkins, 1912, who has been in charge of a missionary hospital in Saskatchewan for the last six years, has returned to Toronto for the winter.

Miss Constance Nettleton, 1919, who has been with the Victorian Order of Nurses in Vancouver, has accepted a position with the Department of Public Health, Toronto.

Miss Annie Edgar, 1917, has returned to India.

Miss Marion Hartstone, 1921, is at present at her home in Peterborough.

Miss Jean Young, 1924, has accepted the position of night supervisor at Galt General Hospital, her duties having commenced on November 1st.

Miss Marjorie Ingall, 1926, is engaged in public health nursing in Swansea, Ont.

Miss Clara Wheatley, 1920, has resigned her position at the Toronto General Hospital and is doing private duty nursing in Montreal.

Misses Helen Barnett, 1921; Thelma D. Green, 1922; and Eleanor Wheler, 1924, have joined the staff of the Rockefeller Hospital, New York City.

Misses Jean Gillis, 1921, and Beatrice Snider, 1922, are doing private duty nursing in New York.

Miss Ella Addison, 1924, has resigned from the staff of the Rockefeller Hospital and is at present at home.

Miss Vera Pearson, 1918, has resigned her position at the Brantford General Hospital and is residing in Montreal.

The sincere sympathy of the Alumnae is extended to Miss Georgina Howell in the loss of her father.

Toronto Western Hospital: The Alumnae of the Toronto Western Hospital has organized a bridge in the residence of the school to raise funds for the continuation of their scholarship and a stork shower in the home of one of its members to provide layettes for patients in the Alexandra Wing of the hospital.

Miss Rahno Beamish, 1919, has been awarded a scholarship by the Alumnae Association and is taking the administration course at the School for Graduate Nurses, McGill University. Miss Gladys Sharpe, 1920, is taking that course also.

New appointments to the staff of the hospital are: Miss Mary McCamus, 1920, instructress in theory for the probation class; Miss Gwaldlyn Jones, 1927, assistant supervisor in the Alexandra Wing, and Miss Elaine Playle, 1927, supervisor of female surgery.

DISTRICT 8

Two temporary appointments have been made to the Central Office staff of the Victorian Order in Ottawa: Miss Dorothy Cotton (McGill University) and Miss

Dorothy M. Percy (University of Toronto). Miss Cotton will be engaged in supervisory and Miss Percy in educational work.

Miss Louise Grover (University of Toronto) has joined the Victorian Order in Renfrew, and Miss Archange Labelle (University of Montreal) in Pembroke.

DISTRICT 10

The regular meeting of the Registered Nurses Association was held on October 12th, 1927, in the McKellar General Hospital Nurses' Home, Fort William, with thirty-eight members present. A report from the Nursing Education Section was read by Miss P. Morrison dealing with the home nursing classes and educational standard of nurses entering training schools.

Dr. C. C. McCullough gave an interesting address in which he compared favourably the hospitals of Canada with those of Europe and gave a colourful account of London, Berlin and Vienna, from economic and medical standpoints. Dr. McCullough concluded his remarks by a vivid description of the unveiling of the Canadian Soldiers' Memorial at Mons.

A musical programme and luncheon concluded the evening's entertainment.

QUEBEC

MONTREAL

Royal Victoria Hospital

At the meeting of the Alumnae Association held in the Nurses' Home on October 12th, 1927, Miss Allder expressed the deep regret felt by all members of the Association at the great loss sustained by the nursing world in the death of Miss Flora Madeline Shaw.

The following nurses of the Royal Victoria Hospital are attending the course at McGill University: Miss M. Bliss, Miss Margaret Pringle, and Miss Marion Clarke.

Miss M. White and Miss Gladys McNutt, 1924, are doing private duty nursing in New York City.

Miss Eleanor McKean, 1923, has accepted a position on the staff of the Royal Edward Hospital, Paget, Bermuda, and leaves shortly to take up her new duties.

Miss Spriggs, 1925, is now in charge of the 2nd floor, Ross Pavilion.

Of this year's graduates the following have been appointed to the nursing staff of the hospital, viz.: Miss James, Ward G; Miss Sharp, Ward B, and Miss S. McRae, Ward E.

The Western Hospital

The annual Alumnae dinner was held on the evening of October 10th at the Ritz Carlton Hotel, a large number of the members being present.

The guests of the evening included Miss Mabel Holt, of the Montreal General Hospital, and those members of the graduating class of the Montreal General Hospital who had entered the school at the Western Hospital just prior to the amalgamation of the two institutions. Miss Holt gave a very inspiring address to these nurses.

Toasts were drunk to the King, the Guests, the Staff Nurses, the Doctors, the Former Graduates and Alma Mater. The musical programme included vocal solos by Mrs. Angus Barwick and Miss Violet Cross.

At the bazaar held by the Montreal Graduate Nurses Association in aid of the Nurses' Club the Western Hospital Alumnae will have charge of the Baby Shop; convener, Miss B. Birch.

Mrs. Victor Sargent (Helen Rowley) recently paid a short visit to Montreal, the guest of her mother.

Montreal General Hospital

At the October monthly meeting of the Alumnae Association Mr. Whitfield Aston gave an interesting address on Charles Dickens.

Miss Dodds, who is in charge of the I.O.D.E. Tubercular Hospital, Sherbrooke, P.Q., is a patient in the Montreal General Hospital.

Miss Marion Miller, 1927, and Miss Sadie McIsaac, 1927, are doing floor duty in ward "R" at the M.G.H.

Miss Donaldson is relieving in the Out Patient Department, M.G.H., for a short time.

Miss Russell, a graduate of the Hospital for Sick Children, Toronto, is in charge of the children's ward, M.G.H., succeeding Miss Grindley, also a graduate of the former hospital.

Sympathy is extended to Miss Gwendolin Nichol and Mrs. James Johnston on the death of their brother, Dr. Stuart Nichol; to Miss Marjorie McDonald on the death of her mother; and to Miss Winnifred Scott, on the death of her father.

QUEBEC

The Alumnae Association of Jeffery Hale's Hospital held a very enjoyable bridge on the night of October 25th. There were sixty tables and a prize for each table. There was also a fish pond, from which much fun was derived, and two fortune tellers were kept quite busy: one reading the cards and the other one reading palms. Home-made candy was sold during the evening, and also beautiful cut flowers. At the close of the evening various valuable articles donated by the public were sold by auction. The bridge party was given in aid of Jeffery Hale's Hospital and nearly $900 were realized and handed over to the Board of Governors, to be used for the hospital in whatever way they considered most advisable. The party was under the convenership of Miss H. A. MacKay, assisted by a very able committee.

Victorian Order of Nurses

Miss Elizabeth L. Smellie, R.N., R.R.C., chief superintendent of the Order, attended the interim conference of the International Council of Nurses held in Geneva in July, and while there delivered a paper on "The Advantages and Disadvantages of Standardization of Nursing Technique."

Miss Isabel Manson, who was awarded a scholarship by the Victorian Order of Nurses to take the international course given under the auspices of the League of Red Cross Societies at Bedford College, London, England, has returned and is on the Montreal staff.

Miss Margaret Moag, district superintendent, Montreal, who took post-graduate work in Cleveland, has returned to Montreal.

Miss Jean Leveson (University of British Columbia) is on the Edmonton staff.

Miss Florence Erickson (University of British Columbia) is with the Order in Burnaby, B.C.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BAILEY—In October, 1927, to Mr. and Mrs. Bailey (Toronto General Hospital, 1918), of Port Credit, Ont., a son.

BROOKS—On October 30th, 1927, to Mr. and Mrs. W. Brooks (Edith Gresham, Toronto Western Hospital, 1920), a son.

BURTON—On October 15th, 1927, to Mr. and Mrs. Lewis H. Burton (Edith Lindsay, General Public Hospital, Saint John, 1917), a son, Edgar Addy.

DICKSON—Recently, at Utica, N.Y., to Dr. and Mrs. W. Dickson (Anna McLellan, Toronto General Hospital, 1922), a son.

GEDDIE—On October 16th, 1927, to Mr. and Mrs. Gordon L. Geddie (Florence M. Armstrong, General Public Hospital, Saint John, 1913), a son, John.

MILLARD—On October 28th, 1927, at Brantford, to Dr. and Mrs. Reg. Millard (Anna McCullough, Brantford General Hospital, 1913), a daughter.

MILLS—On October 18th, 1927, at Toronto, to Mr. and Mrs. Paul Mills (Clara Chisholm, Toronto General Hospital, 1919), a son.

ROBERTSON—On October 27th, 1927, to Mr. and Mrs. Grant Robertson (Bobbie Haight, Regina General Hospital), of Regina, Sask., a son.

ROBERTSON—Recently, at Montreal, to Mr. and Mrs. Percy Robertson (Christine Rowley, Western Hospital, Montreal), a daughter.

SMYTHE—On October 18th, 1927, at Toronto, to Mr. and Mrs. John Smythe (Toronto General Hospital, 1918), a daughter.

WILLIS—On November 7th, 1927, to Mr. and Mrs. J. S. Willis (Mary Fleck, Grace Hospital, Toronto, 1918), a daughter.

MARRIAGES

ALLISON—PARKS—On October 22nd, 1927, Evelyn Mercedes Parks (Toronto General Hospital, 1925) to Vernon Ross Allison, of Adolphostown.

BALL—MORRISON—At Montreal, in October, 1927, Josephine Morrison (Royal Victoria Hospital, 1925) to Allan S. Ball.

BIRD—CURRIE—On September 10th, 1927, Janet (Maisie) Currie (Montreal General Hospital, 1924) to Major Frederick Bird.

BURDEN—FEAR—On October 22nd, 1927, at Springhill, Nova Scotia, Beatrice Fear (General Public Hospital, Saint John, N.B., 1924) to James W. Burden, of Glace Bay. At home—Glace Bay, N.S.

CASS—HILL—In October, at Outremont, P.Q., Muriel Helen Hill (Montreal General Hospital) to Norman D. Cass, of Ottawa.

CUNNINGHAM—McGILL—In October, 1927, at Nanaimo, B.C., Constance McGill (St. Joseph's Hospital, Victoria, 1924) to Cecil Cunningham. At home—Nanaimo, B.C.

DAWSON—SMYTHE—On June 4th, 1927, at Port Hope, Mildred Muriel Smythe (Toronto General Hospital, 1926) to Gerald L. Dawson, of Bailieboro, Ont.

DICK—ROY—On October 22nd, 1927, in San Francisco, Cecelia Roy (St. Joseph's Hospital, Victoria, 1923) to E. Dick. At home—Los Angeles, Calif.

DONOVAN—RADCLIFFE—On October 15th, 1927, at Toronto, Gertrude Radcliffe (Toronto General Hospital, 1916) to Harry Donovan, of Oakville, Ont

DRINNAN—HENDRIE — On September 17th, 1927, at Knox Church, Calgary, Agnes (Nan) B. D. Hendrie to Andrew Whitelaw Drinnan. Home address, 1016 14th Avenue West, Calgary, Alberta.

ERSKINE—CARMICHAEL—On October 15th, 1927, at Knowlton, P.Q., Emma Carmichael to Douglas W. Erskine.

HANSON—RITCHIE—On October 12th, 1927, at Halifax, N.S., Margaret Elizabeth Ritchie (Waltham Hospital, Waltham, Mass, 1926) to David Hanson. At home—Waltham, Mass.

JONES—TITUS—On October 26th, 1927, Harriet Titus (Chipman Memorial Hospital, St. Stephen, N.B., 1927) to Arthur A. Jones.

LeBEAN — GUERNSEY — At Bowmanville, Ont., in October, 1927, Beatrice Guernsey (Royal Victoria Hospital, 1907) to Mr. LeBean. Outremont, P.Q.

LEITHBRIDGE — HENDSBEE — On October 24th, 1927, at Dartmouth, N.S., Jennie Alice Hendsbee (Halifax Infirmary) to Henry Clayton Leithbridge.

MORRISON—ALLEN—Recently, at Toronto, Mary Winnifred Allen (Toronto General Hospital, 1922) to William A. Morrison, of Listowel, Ont.

MUNROE—TRIDER—On October 15th, 1927, at Dartmouth, N.S., Marjorie Anne Trider (Nova Scotia Hospital, Halifax) to Harold Alfred Munroe. At home—Cameron St., Dartmouth, N.S.

MURRAY — SMITH — On November 7th, 1927, at Halifax, Ruth Smith (Royal Victoria Hospital, 1925) to Ken Murray.

REDDY—BIGELOW — On October 14th, 1927, in Montreal, Agnes Keating Bigelow (Royal Victoria Hospital, 1925) to Eric B. F. Reddy. At home—4515 Chomedy St., Montreal.

REID — COLPITT — On September 24th, 1927, in Halifax, Mildred Colpitt (Royal Victoria Hospital) to Dr. James W. Reid. At home — Brooklyn, Hants County, Nova Scotia.

SMITH—CROOK—On October 4th, 1927, at Halifax, N.S., Helen Evangeline Crook (Aberdeen Hospital, New Glasgow) to Eldred Smith. At home— Yarmouth, N.S.

TALLMAN — RINGWOOD — On October 17th, 1927, in Edmonton, Eileen Ringwood (University Hospital, Edmonton. 1926) to Dr. Frank Tallman. At home —Ponoka, Alberta.

THORNE — BELDING — Recently, at Lynn, Mass., Marguerite Belding (General Public Hospital, Saint John, 1926) to Robert W. Thorne, of Lynn, Mass.

DEATHS

ALMOND—At Borse, Idaho, U.S.A., in October, 1927, Mrs. Willis Almond (nee Nyhl Picken, Royal Victoria Hospital, 1918).

ELLIOTT—At Murray Hill Sanatorium, New York, on October 10th, 1927, Mrs. Nan C. Elliott (Public General Hospital, Saint John, 1913), second daughter of Mr. and Mrs. W. G. J. Watson, of this city.

McCLURE—On September 11th, 1927, at Fairbanks, Alaska, Mrs. J. McClure (Carrie Haggon, St. Joseph's Hospital, Victoria, B.C., 1917).

MORRISON—On October 7th, 1927, at Toronto, Kate Morrison (Grace Hospital, Toronto, 1899).

Important:—All nurses wishing to join the College of Nursing, whose names are not on the General Part of the State Register for England and Wales, must do so before March 31st, 1928. Present requirements are: a three years' certificate of general training from an approved training school; good character. For application forms write to the Secretary, College of Nursing, 1a Henrietta Street, London, W. 1.

The biennial meeting of the Canadian Nurses Association will be held from July 3rd to 7th, in Winnipeg, Manitoba.

The annual meeting of the Association of Registered Nurses for Province of Quebec will be held on January 30th and 31st, 1928, in Montreal.

THE CANADIAN NURSE

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Feet—The Most Important Ally of the Nurse

Do nurses realize the importance of foot health, both for themselves and their patients?

Like the majority of womankind. they want the maximum of style (off duty, certainly nurses are as well dressed as any other business women).

It is of the utmost importance, however, that FEET should be the primary consideration of the nurse in the care of her health.

They are her servants on whom she depends, as she does on no other physical asset, except perhaps her eyes.

If she is bothered with feet that perspire easily, that are hot, that are encased in shoes, no matter what the price, which do not give her support and comfort. then all the other care she gives to her health is in vain.

And so many women, not only nurses, bathe and rub and massage for tired feet when, if they gave extra thought to their shoes, their troubles would be eliminated.

And it is not necessary to have shoes that are a comfort when on duty only, but also shoes that are comfortable when worn on the street, in the home, or society, and it is now possible to combine both. No longer is it necessary to wear shoes which look comfortable, but are nothing else, shoes that might certainly provide foot health, but which do not contribute to the beauty of the general ensemble.

They are now made by specialists who have combined beauty and utility. Certainly one cannot hope to have the grace of carriage and the poise of general well being which should be a part of the nurse's make up if some thought is not given to this very necessary servant, not only of the nurse, but of every woman who prizes that proud possession—poise.

The superintendents of nurses in our hospitals, while demanding for the staff no particular make of shoe, generally states which she prefers and suggests a good make. What she does demand is that the shoes be equipped with low (rubber) heels and that the soles be wide enough for comfort. Certainly the nurse of all people cannot go around with the high heel affected by her sisters who do not have to depend upon their pedal appendages to such an extent.

If, therefore, the comfort of the feet is so important to the nurse it surely should be to all, and nurses could do a great deal towards the ultimate health of their patients if they would put in a word for the manufacturers of shoes who have studied this matter and who turn out an article not solely with an eye to style.

At least one manufacturer we know makes a shoe that is especially adapted to the expectant mother. Women particularly because they demand more "style" with their shoes, frequently suffer from chronic backache, headache, and "nerves." Were their feet properly shod they would become what nature intended: healthy and happy human beings.

Corns and bunions and callouses are not necessary, and nurses can do a great deal towards preaching the gospel of good health through attention to feet. Remember, it is not necessary to sacrifice appearance to comfort. One can have both, combined with the graceful carriage and poise of the man or woman who looks the world in the face with courage because they are not handicapped with the "little things" which, we are told, like the sand in the shoe, irritate more than the bigger problems of life.

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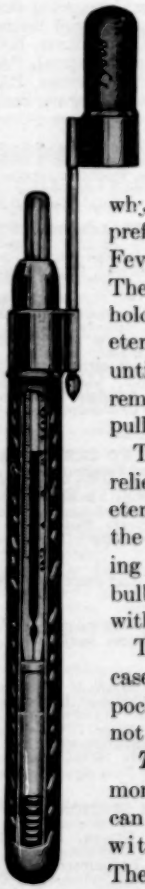

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President, Miss Vera Malone, 168 Isabella St.; Vice-President, Miss Edith Cowan, 100 Gloucester St.; Corresponding Secretary, Miss Edith L. Carson, 72 Homewood Ave.; Recording Secretary, Miss Marion Wansbrough, 5 Maitland Place; Treasurer, Miss Kathleen Leyton, 38 Helendale Ave.; Members of Executive, Mrs. Barry, Misses McFall, Anderson and Harrison; Representatives to Central Registry, Miss Helen Carruthers, 112 Bedford Rd., and Miss Elda Rowan; Correspondent to "The Canadian Nurse," Miss Ina Onslow, 100 Gloucester St.

TORONTO WESTERN HOSPITAL ALUMNAE ASSOCIATION

Hon. President, Miss B. L. Ellis; President, Miss Wiggins; Vice-President, Miss Grace Sutton; Recording Secretary, Miss Ryde; Secretary-Treasurer, Miss Marjorie Agnew; Representative to R.N.A.O., Miss Lena Smith; Representative to "The Canadian Nurse," Miss McDougall; Representatives to Local Council of Women, Mrs. McConnell, Mrs. Heuston; Councillors, Mrs. Yorke, Misses Cooney, Phillips, Cook, McLean, Elva, Hewitt; Social Committee, Miss Smith, Miss Bishop.

Meetings—Second Tuesday each month, at 8 p.m., in Assembly Room of Western Hospital.

ALUMNAE ASSOCIATION WOMEN'S COLLEGE HOSPITAL, TORONTO

Hon. President, Mrs. H. M. Bowman; President, Miss B. Stillman; Vice-Presidents, Miss Scott and Miss Fraser; Treasurer, Miss Chalk; Corresponding Secretary, Miss B. Peacock; Recording Secretary, Miss D'Arcy Barrie; Representatives to Local Council, Mrs. S. Johnson and Miss Patterson; Representatives to Private Duty Section, Miss Ennis and Miss Worth; Representative to "The Canadian Nurse," Miss L. Shaw.

THE ALUMNAE ASSOCIATION OF THE CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL FOR CONSUMPTIVES, WESTON, ONT.

Hon. President, Miss E. MacP. Dickson; President, Miss Hazel Dixon, Reg.N., Toronto Hospita for Consumptives; Vice-President, Miss Ella Robertson, Reg. N., Toronto Hospital for Consumptives; Secretary, Miss Josephine Wik, Reg.N., Toronto Hospital for Consumptives; Treasurer, Maude Powell, Reg.N., Toronto Hospital for Consumptives.

THE ALUMNAE ASSOCIATION OF THE WOODSTOCK GENERAL HOSPITAL TRAINING SCHOOL FOR NURSES

Hon. President, Miss Frances Sharpe; President, Mrs. J. McDiarmid; Vice-President, Miss L. M. Davidson; Recording Secretary, Miss Gladys Jefferson; Corresponding Secretary, Miss Jane Read, 375 Ingersoll Ave.; Treasurer, Miss H. Hamilton; Representative, The Canadian Nurse," Miss Anne Kerr.

GRADUATE NURSES' ASSOCIATION OF THE EASTERN TOWNSHIPS

Hon. President, Miss H. Buck; President, Miss H. Buchanan; First Vice-President, Miss D. Ingraham; Second Vice-President, Miss D. Stevens; Corresponding Secretary, Miss M. Robins, 17 Magog St., Sherbrooke, P.Q.; Recording Secretary, Miss H. Hetherington; Treasurer, Mrs. Gordon Edwards.

LACHINE GENERAL HOSPITAL ALUMNAE ASSOCIATION

Hon. President, Miss L. M. Brown; President, Mrs. McL. Murray; Vice-President, Miss K. Mason; Secretary-Treasurer, Mrs. D. H. Balmain, 383 St. Catherine St., Lachine, P.Q.

Regular Meeting—Second Monday of each month, at 8.15 p.m.

MONTREAL GRADUATE NURSES' ASSOCIATION

President, Miss L. C. Phillips, 3626 St. Urbain St.; First Vice-President, Miss C. V. Barrett, Royal Victoria Maternity Hospital; Second Vice-President, Miss Muriel Stewart, 99 Northcliffe Ave.; Secretary-Treasurer, Miss Susie Wilson, 38 Bishop St.; Registrar, Miss Lucy White, 38 Bishop St.; Asst. Registrar, Miss Helen S. Hill, 38 Bishop St.; Convener, Griffentown Club, Miss G. H. Colley, 261 Melville Ave., Westmount, Montreal.

Regular Meeting—First Tuesday in each month, at 8.15 p.m.

A.A. CHILDREN'S MEMORIAL HOSPITAL, MONTREAL

Hon. President, Miss A. Kinder; President, Miss E. Way; Vice-President, Miss D. Parry; Treasurer, Miss F. B. Laite; Secretary, Miss E. M. Hillyard; Representative, "The Canadian Nurse," Miss M. Wight; Representative, Private Duty Section, Miss Helen MacDonald; Sick Nurses Committee, Miss J. Chisholm, Miss E. Keegan; Members of Executive Committee, Mrs. C. H. P. Moore, Miss I. Lennon.

MONTREAL GENERAL HOSPITAL ALUMNAE ASSOCIATION

President, Miss C. Watling; First Vice-Pres., Miss S. E. Young; Second Vice-Pres., Miss McNutt; Recording Secretary, Miss M. Boa, Western Division, Montreal General Hospital; Treasurer Alumnae Association, Miss R. Stericker, 372 Oxford Ave., Montreal; Treasurer Sick Benefit Fund, Miss H. Dunlop, 223 Stanley St., Montreal; Corresponding Secretary, Miss A. E. Ward, Montreal General Hospital; Executive Committee, Misses E. F. Strumm, L. White, F. L. Reed, M. Batson; Representative to "The Canadian Nurse," Miss Agnes Jamieson, 38 Bishop Street, Montreal; Representative to Private Duty Section, Miss Meigs, 6 Oldfield Ave., Montreal; Representatives to Local Council of Women, Miss Wainwright, Miss Colley; Sick Visiting Committee, Mrs. Lamb, Misses J. Murphy, M. Martin, M. Ross.

THE ALUMNAE ASSOCIATION OF THE HOMEOPATHIC HOSPITAL, MONTREAL, QUE.

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ALUMNAE ASSOCIATION OF THE ROYAL VICTORIA HOSPITAL, MONTREAL, P.Q.

Honorary Presidents, Miss Draper, Miss Hersey; President, Mrs. Alma Stanley; First Vice-President, Miss Ethel Reid; Second Vice-President, Mrs. F. A. Scrimger; Recording Secretary, Mrs. Ray Roberts; Corresponding Secretary, Miss Marjorie Dobie; Treasurer, Miss Mabel Burdon. Executive Committee, Mrs. Stanley, Misses Goodhue, K. Davidson, A. M. Campbell, A. Deane; "The Canadian Nurse" Representative, Miss Helen Clark; Representatives to Local Council of Women, Miss A. M. Hall, Miss Gertrude Yeats; Convener Sick Visiting Committee, Miss Ethel Gall; Finance Committee, Misses Hersey, Goodhue, MacLellan, Enright, Maud Wright, Elsie Allder, Mrs. Stanley.

THE WESTERN HOSPITAL, MONTREAL, ALUMNAE ASSOCIATION

Honorary President, Miss Jane Craig; President, Miss Elizabeth Wright; First Vice-President, Mrs. Percy Robertson; Second Vice-President, Miss Edna Corbett; Secretary, Miss Ruby Kett; Treasurer, Miss Jane Craig; Conveners of Committees, Membership and Visiting, Miss Beatrice Dyer, Programme, Miss Marion Gillespie; Finance, Miss Evelyn MacWhirter. Representative to "The Canadian Nurse," Miss Olga V. Lilly.

THE ALUMNAE ASSOCIATION OF THE WOMEN'S HOSPITAL, MONTREAL

Hon. President, Miss E. F. Trench; President, Mrs Crewe; First Vice-President, Mrs. Chisholm; Second Vice-President, Miss Morrison; Recording Secretary, Miss N. Brown; Corresponding Secretary, Miss L. Commerford; Treasurer, Miss E. F. Trench; Representative to "The Canadian Nurse," Miss E. L. Francis; Sick Visitors, Mrs. Kirk and Miss Smiley Private Duty Representative, Miss Seguin.

Regular Meeting—Third Wednesday, at 8 p.m.

ALUMNAE ASSOCIATION OF JEFFERY HALE'S HOSPITAL, QUEBEC

Hon. President, Mrs. S. Barrow; President, Miss Elsie Walsh; First Vice-President, Miss A. Armour; Second Vice-President, Mrs. C. Young; Treasurer, Miss Muriel Fischer; Recording Secretary, Mrs. D. Jackson; Corresponding Secretary, Miss H. A. Mackay; Representative to "Canadian Nurse," Miss E. Fitzpatrick; Sick Visiting Committee, Misses G. Mayheu and Effie Jack; Private Duty Section, Miss Dorothy Ford; Councillors, Miss Dorothy Ford, Mrs. Craig, Mrs. L. Teakle, Miss C. Bignell and Miss Sims.

SHERBROOKE HOSPITAL ALUMNAE ASSOCIATION

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MOOSE JAW GRADUATE NURSES' ASSOCIATION

Hon. Advisory President, Mrs. Harwood; Hon. President, Mrs. Lydiard; President, Miss V. Winslow; First Vice-President, Mrs. Metcalfe; Second Vice-President, Miss L. Wilson; Secretary, Miss I. G. Bambridge, Moose Jaw General Hospital; Conveners of Committees: Press, Mrs. Phillips; Programme, Miss Latham; Social, Mrs. Lydiard; Constitution and By-Laws, Miss Stocker; Private Duty, Miss F. Whe-ler; Public Health, Miss Riddell; Nursing Education, Mrs. Young; Representative to "The Canadian Nurse," Miss Stanser; Treasurer and Registrar, Miss C. Kier.

ALUMNAE ASSOCIATION OF GREY NUNS' HOSPITAL SCHOOL OF NURSING, REGINA, SASK.

Hon. President, Rev. Sister O'Grady, Superintendent of Nurses; President, Mrs. Agnes Tanney, Dept. of Public Health, Regina; First Vice-President, Mrs. Davis; Second Vice-President, Miss Rutherford; Secretary-Treasurer, Mrs. L. Smith, Grey Nuns' Hospital, Regina; Executive Committee, Misses Margaret Donnelly (Convener), 102 Davin Blk., Regina, Helen McCarthy, Edith Campbell, Mrs. G. Lewis; Representative, The Canadian Nurse, Miss Helen McCarthy, 1835 Victoria Ave., Regina; Sick Visiting Committee, Miss Warbeck (Convener), Miss James, Mrs. MacKay; Social Committee, Misses Gillis, O'Connor, Lambert, Cockwell, Jean Horty; Representative Social Council of Women, Mrs. Agnes Tanney, Miss Helen McCarthy; Membership Committee, Miss Edith Campbell, 2073 Cornwall St., Regina; Representative, Private Duty Section, Miss Elizabeth McQuatt; Representative, Nurses' Registry, Mrs. Agnes Tanney.

Regular meeting held second Thursday of each month at the Nurses' Residence.

A.A. SCHOOL FOR GRADUATE NURSES, McGILL UNIVERSITY, MONTREAL, P.Q.

Hon. Members, Miss M. F. Hersey, Miss S. E. Young, Miss G. M. Fairley, Dr. Helen R. Y. Reid, Dr. Maude Abbott, Miss Mary Samuel; President, Miss F. L. Reed; Vice-President, Miss L. Dickson; Secretary-Treasurer, Miss D. Cotton; Representatives, Local Council of Women: Miss E. Sharpe, Miss G. Martin; Proxies, Local Council of Women: Miss M. Nash, Miss H. Hewton; Canadian Nurse Representatives: Administration, Miss F. Upton; Teaching, Miss K. Scott; Public Health, Miss M. Matthews; Convener Programme Committee, Miss M. Boa.

ALUMNAE ASSOCIATION OF THE DEPARTMENT OF PUBLIC HEALTH NURSING, UNIVERSITY OF TORONTO

Hon. President, Miss E. K. Russell; President, Miss C. B. Vale; Vice-President, Miss L. Beatty; Secretary-Treasurer, Miss C. Sparrow; Recording Secretary, Miss L. Radmore; Conveners of Committees: Programme, Miss W. Walker; Social, Miss C. Cale; Publicity, Miss A. O'Connor.

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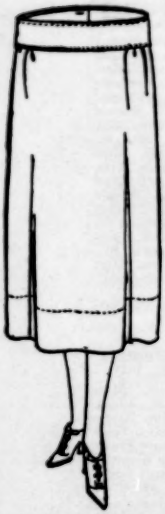

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